2014: SEEKING PPACA ANSWERS

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

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2014: SEEKING PPACA ANSWERS

THURSDAY, JANUARY 16, 2014

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 9:33 a.m., in room 2123 of the Rayburn House Office Building, Hon. Tim Murphy (chairman of the subcommittee) presiding.

Present: Representatives Murphy, Burgess, Blackburn, Gingrey, Harper, Olson, Gardner, Griffith, Johnson, Long, Ellmers, Upton (ex officio), DeGette, Braley, Schakowsky, Butterfield, Castor, Welch, Tonko, Yarmuth, and Green.

Staff present: Carl Anderson, Counsel, Oversight; Gary Andres, Staff Director; Sean Bonyun, Communications Director; Karen Christian, Chief Counsel, Oversight; Noelle Clemente, Press Secretary; Brad Grantz, Policy Coordinator, Oversight and Investigations; Brittany Havens, Legislative Clerk; Sean Hayes, Counsel, Oversight and Investigations; Alan Slobodin, Deputy Chief Counsel, Oversight; Tom Wilbur, Digital Media Advisor; Brian Cohen, Democratic Staff Director, Oversight and Investigations, and Senior Policy Advisor; Hannah Green, Democratic Staff Assistant; Elizabeth Letter, Democratic Press Secretary; Stephen Salsbury, Democratic Special Assistant; and Matt Siegler, Democratic Counsel.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Good morning. I convene this hearing on the Subcommittee on Oversight and Investigations to review the implementation of the Patient Protection and Affordable Care Act.

Our witness today is Mr. Gary Cohen, the Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services. Mr. Cohen, I would like to read you two quotes from your testimony before the committee last year. On April 24, 2013, when asked by the ranking member for benchmarks to measure CCIIO's progress, you responded: and I quote, "I think the keys are that we are on schedule and on track with the IT build that were doing, which is clearly an important part of this." And then you added, "I think it is just important to take a look at each of the steps along the path and make sure that we are on track. But I am very

optimistic and confident of where we are at this point." Again, this was on April 24, 2013.

Here is a second quote. On September 19, less than 2 weeks before the start of open enrollment, when Dr. Burgess asked you if open enrollment would be ready on October 1st, you said: "Consumers will be able to go online, they will be able to get a determination of what tax subsidies they are eligible for, they will be able to look at the plans that are available where they live, they will be able to see the premium net of subsidy that they would have to pay, and they will be able to choose a plan and get enrolled in coverage beginning October 1st." When pressed further, you responded: "I have nothing further to add to my answer."

Now, those unqualified statements that the exchanges would be ready by October 1st are now contrasted against what we have learned through our investigation since the Healthcare.gov Web site failed on launch.

Mr. Cohen, on April 4 and 5, 2013, just 3 weeks before you told this committee that you did not have any question about the exchanges being ready on October 1st, the McKinsey Company briefed you and a number of other members of the Administration teams on this on a number of risks facing the Web site and the federal marketplace. Those included late policy, delayed designs and building time, and a limited time to test the Web site. I would like to know why did you feel confident telling this subcommittee on April 24th that everything was on track? Similarly, CMS's own emails from the summer of 2013 show that CMS officials were worried that Healthcare.gov would "crash on takeoff" and yet, you again told us in September that everyone would be able to go online, select a plan, learn their subsidy, and enroll starting October 1st.

Mr. Cohen, I thank you for being here today, and I know the number of times you have made yourself available to testify to this committee and I do appreciate that. But it seems like you are faced with two alternatives today: either you didn't know about the problems with Healthcare.gov when you testified last year, or you did, and decided not to inform Congress.

Now, this is part of a pattern for this Administration and the Affordable Care Act that is so disheartening to the American people: promises made and promises broken. We have spent over $600 million on the Healthcare.gov Web site and the Administration gave absolutely no warning that a disaster was approaching, and now we know those warnings were obviously there.

The broken promises don't end there. After years of saying if you like your plan you can keep it, the president finally apologized. And what about the $2,500 in premium savings the President promised? We don't hear that promise anymore. And now recent news reports have discussed narrow provider networks as a consequence of Obamacare. Will Americans still be able to keep their doctors? And now we ask, will they be able to afford their deductibles?

This hearing is not just about looking backward and determining who knew what about the Web site. But one important purpose of this hearing is accountability. So I would like us to try and start fresh in 2014, but our ability to do so depends on you explaining fully and honestly what you knew and what you understood about

the development of the exchanges and Web site as it was happening, and how that informed your testimony last year to this committee. Because, as we have often said, this is about more than a Web site. If people are to trust and rely on this system, and trust something so critically important to a family as their own health care, this Administration needs to have an honest and open dialogue with the public about the status of the implementation. Promises of all is well just don't cut it anymore.

With the start of coverage just a few weeks ago, there are many important issues to examine about how the exchanges are operating. If problems are looming, we need to get the facts on the table and do something about it before it is too late. Mr. Cohen, I hope you will give complete answers today to the following questions: Why didn't you tell Congress last year about the problems with Healthcare.gov? How many people have actually paid their insurance premiums in the exchanges? Of those people who have paid their premiums, how many were uninsured and how many had their plans actually cancelled? How much will the taxpayers end up spending on the Healthcare.gov Web site, and where are you getting the money for it? News reports have stated that not enough young people are enrolling. When will we know about the risk corridors, and whether the federal and state exchanges are sustainable?

[The prepared statement of Mr. Murphy follows:]

PREPARED STATEMENT OF HON. TIM MURPHY

I convene this hearing on the Subcommittee on Oversight and Investigations to review the implementation of the Patient Protection and Affordable Care Act.

Our witness this morning is Mr. Gary Cohen, the Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare & Medicaid Services. Mr. Cohen, I would like to read you two quotes from your testimony before the committee last year:

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Mr. Cohen, I thank you for being here today. I know the number of times you have made yourself available to testify to this committee and I do appreciate it. But it seems like you are faced with two alternatives today: either you didn't know about the problems with HealthCare.gov when you testified last year, or you did, and decided not to inform Congress.

This is part of a pattern for this administration and the Affordable Care Act that is so disheartening to the American people. Promises made, promises broken. We have spent over $600 million on the HealthCare.gov Web site and the administration gave absolutely no warnings that a disaster was approaching-and now we know those warnings were obviously there. The broken promises don't end there. After years of saying that "if you like your plan you can keep it", the president finally apologized. What about the $2,500 in premium savings the president promised? We don't hear that promise anymore. Now recent news reports have discussed narrow provider networks as a consequence of the Affordable Care Act. Will Americans still be able to keep their doctors? Will they be able to afford their deductibles?

This hearing is not just about looking backward and determining who knew what about the Web site. But one important purpose of this hearing is accountability. Mr. Cohen, we would like to try and start fresh in 2014, but our ability to do so depends on you explaining fully and honestly what you knew and what you understood about the development of the exchanges and Web site as it was happening, and how that informed your testimony last year to this committee. Because, as we have often said, this is about more than a Web site. If people are to trust and rely on this system, this administration needs to have an honest and open dialogue with the public about the status of implementation. Promises of "all is well" just don't cut it anymore. With the start of coverage just a few weeks ago, there are many important issues to examine about how the exchanges are operating. If problems are looming, we need to get the facts on the table and do something about it before it is too late. Mr. Cohen, I hope you will give complete answers today to the following questions:

- Why didn't you tell Congress last year about the problems with HealthCare.gov?
- How many people have actually paid their insurance premiums in the exchanges?
- Of those people who have paid their premiums—how many were uninsured and how many had their plans cancelled?
- How much will the taxpayer end up spending on HealthCare.gov, and where are you getting the money for it?
- News reports have stated that not enough young people are enrolling. When will we know about the risk corridors, and whether the federal and state exchanges are sustainable?

# # #

Mr. MURPHY. So I thank you for being here today, and I yield now to the ranking member, Ms. DeGette, for 5 minutes.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Well, thank you, Mr. Chairman, and welcome, Mr. Cohen, back to this committee.

I think, Mr. Chairman, we could probably stipulate to the fact that Healthcare.gov had a rocky start. There is no doubt about that. But I am sitting here thinking, the longer the Republicans keep beating the dead horse about who knew what, when and all of that, the longer they keep raising these faux issues like the fact that they say the Web site is not secure, then I think the worst it is going to be for their constituents because after all, isn't our desire to encourage people to sign up for health insurance, if they are eligible for Medicaid, to sign up for Medicaid, if they are eligible for subsidies, to get those subsidies to help pay for their insurance?

As I hear my colleagues on the other side of the aisle talk about this, I can't help but wonder if they really do want their constitu-

ents to have insurance. Last week's vote on the floor was a good example where we voted on this bill that said that we were going to have security in Healthcare.gov. Now, everybody thinks we need to have security in Healthcare.gov but the clear impression given during the floor debate and also the debate in this committee before that was that somehow Healthcare.gov is not secure when in fact there hasn't been one breach of Healthcare.gov and, in the briefing we had, the federal IT people told us they haven't had any more attempts to breach Healthcare.gov than any other Federal Government Web site, and of course, private Web sites, like, for example, Target, are not exempt from that either.

And so I just can't help but think that my colleagues on the other side of the aisle really don't want to have us implement this Healthcare.gov or the entire Affordable Care Act in a reasonable way. They want to chill their constituents from signing up, and I think that is a darn shame.

The good news is—and believe you me, I was one of the biggest critics on the implementation of Healthcare.gov on this side of the aisle. It was rocky. But the good news is, it does appear now that people are beginning to enroll in this in a robust way.

Last week, Connect for Colorado, which is our state site, announced the figures for my state. We are about halfway through the open enrollment period and already 50,000 Coloradoans have signed up for private insurance on the exchange and about 90,000 have enrolled in Medicaid. So this is 140,000 people who didn't have health insurance before.

Now, this represents real progress. This represents a family that doesn't have to worry about how it will pay for treatment if a child gets sick or has an accident. It represents moms who can get preventive care from breast cancer screenings to vaccines. It represents small businessmen and -women who don't have to worry about losing their livelihood if they have an accident.

Now, I am proud of my governor, I am proud of my legislature, Democrats and Republicans, and I am proud of the leaders for Connect for Colorado for getting it up and going. I know we are not out of the woods yet. We are going to continue to have glitches and we need to address those. But sitting around and trying to figure out what happened last fall when everybody admits it was a disaster does not help us towards fixing this problem in the future.

I want to say one last thing. The White House released enrollment figures for all 50 States earlier this week. The national numbers mirror what happened in my State. Over two million people have signed up on the exchanges and four million people have enrolled in Medicaid. That is six million people who didn't have insurance before.

Now, minority staff released a memo this morning that showed Affordable Care Act enrollment is ahead of where the Medicare Part D enrollment was at the time that program went into effect in 2006. Right now, the Affordable Care Act enrollment is at 31 percent of projected enrollment with half the open enrollment period to go, and at this point during Part D, enrollment had hit only 23 percent of projections, and Mr. Chairman, I would ask unanimous consent to put that memo into the record.

Mr. MURPHY. Without objection.

[The information appears at the conclusion of the hearing.]

Ms. DEGETTE. Thank you.

So you know, I didn't vote for Medicare Part D. Most Democrats didn't. But we worked together to try to make it a success, and I think that is what we should do here.

One of the things I continue to be concerned about with implementation of the Affordable Care Act and the exchanges is enrollment of young people. Now, I know everybody says they will all enroll at the end but I would be interested to know from the Administration what we are doing to make sure we hit those targets because the exchanges are not going to work without them enrolling.

So in sum, let us work together to implement this, to get our constituents enrolled. Let us not sit around griping about what happened admittedly last year.

Thank you, Mr. Chairman.

Mr. MURPHY. The gentlelady yields back. I now recognize the chairman of the full committee, Mr. Upton, for 5 minutes.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. Thank you, Mr. Chairman.

Today we are going to continue our thoughtful oversight of the President's implementation of the health care law and its effects on Americans in Michigan as well as across the country.

So Mr. Cohen, we do welcome you back. You have testified before the committee a number of times and I appreciate you returning again today. In preparing for today's hearing, we went back to review the transcripts, as you would imagine, of your testimony from last year, and when we asked what to expect at the start of open enrollment on October 1st, you assured us on two different times, once in April and again in September, less than 2 weeks before the launch, that yes, everything was on track. And during your more than 4 hours of testimony before the committee last year, there was no mention of the fact that you had been briefed twice by McKinsey in early April of last year and warned about the number of risks facing the marketplaces and the Web site nor was there any elaboration on the fact that CMS employees were well aware that the Web site build was riddled with problems, far behind schedule with the October 1 launch in jeopardy.

So the purpose of today's hearing is not to rehash every detail of the failed launch, but to move forward, we have got to understand what you knew about the status of the Web site and implementation of the President's law at the time that you appeared before the committee, looked us in the eye, and said, of course, everything was on track. It is time to be candid and transparent with Congress and the American public.

Lots of promises have been made, many have already been broken. What is next? The only way the public can trust the health care system and the Administration that is implementing this law is if Administration officials are open and transparent about the facts and what the American people should expect from this law and for their health care moving forward. Providing facts and specifics is an important first step toward restoring the credibility that we all want. The American people deserve the peace of mind that

there will be no more surprises, that the information available is the entire and true story, and I know that you will try to help us understand what happened and provide some answers, and I yield the balance of my time to the vice chair, Dr. Burgess.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Today we continue our thoughtful oversight of the Obama administration's implementation of the health care law and its effects on Americans in Michigan and across the country.

Mr. Cohen, welcome back. You have testified before the committee a number of times and I appreciate you returning again today. In preparing for today's hearing, we went back to review the transcripts of your testimony from last year. When we asked you what to expect at the start of open enrollment on October 1, you assured us on two separate occasions, once in April and again in September less than two weeks before launch, that everything was on track.

During your more than four hours of testimony before the committee last year, there was no mention of the fact that you had been briefed twice by McKinsey in early April 2013 and warned about the number of risks facing the marketplaces and the Web site. Nor was there any elaboration on the fact that CMS employees were well aware that the Web site build was riddled with problems, far behind schedule with the October 1 launch in jeopardy.

The purpose of today's hearing is not to rehash every detail of the failed launch of HealthCare.gov. But to move forward, we must understand what you knew about the status of the Web site and implementation of the president's law at the time you appeared before this committee, looked us squarely in the eye, and proclaimed that everything was "on track." It is time to be fully candid and transparent with Congress and the American people.

Lots of promises have been made, many already broken. What's next? The only way the public can trust this health care system and the administration that is implementing this law is if administration officials are open and transparent about the facts and what the American people should expect from this law and for their health care moving forward. Providing facts and specifics is an important first step toward restoring credibility. The American people deserve the peace of mind that there will be no more surprises, that the information available is the entire and true story. I hope you will help us understand what happened and provide some answers today.

# # #

Mr. BURGESS. I thank the chairman for yielding, and Mr. Cohen, I too want to welcome you back to the committee, and I appreciate the time that you devote to our oversight efforts. But here is the central question: How in the world can we expect people across this country to trust this Administration when they have been continually told that everything will be ready, and in fact it was not.

It is pretty clear now that the Administration knew far more about the concerns prior to the launch of Healthcare.gov before October 1st and yet you came before us on September 19th, and each time you came to this committee in the past year, you promised that Healthcare.gov would be functional October 1st. If I recall your recitation correctly, there were no contingency plans because none were necessary. You insisted to subcommittee members less than 3 weeks before the launch of the federal exchange that everything was on track. I will stipulate that some parts of Healthcare.gov may be working now but they are only working now because a glitch czar had to be appointed after the launch of Healthcare.gov. I don't know how you feel about that but it upsets me that you came before this committee and told us everything was OK. We spent hundreds of millions of dollars. You had well over

3 ½ years to get it right, and then we have got to appoint a glitch czar to sort things out so that people can actually enroll on Healthcare.gov? The enrollment numbers, I think, are meager. Perhaps you have a different story and you will share that with us. But errors, canceled plans, and broken promises, those are just the start.

Now we know that your agency, Health and Human Services, and the White House failed to heed internal warnings about the lack of readiness of the exchanges. It is my hope that you came to this subcommittee prepared to answer your questions. I hope you will set the talking points aside. You owe this to your superiors at HHS, you owe this so the Secretary, you owe this to the President, you owe it to the Congress and, most importantly, you owe it to the American people.

This committee is about oversight. Yes, that requires that we look at the past. Yes, that requires that we look to the future. I think the problems of the past dictate to us that there are going to be significant problems during this first year of Healthcare.gov and you need to be prepared to work with this committee to mitigate the damage that is going to be visited on America's health care system and the American people.

Mr. Chairman, I yield back my time.

Mr. MURPHY. The gentleman yields back. I now recognize Ms. Castor for 5 minutes.

OPENING STATEMENT OF HON. KATHY CASTOR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Ms. CASTOR. Good morning, and thank you, Mr. Chairman, and good morning, everyone.

Mr. Chairman, this is our first hearing of the year on the Affordable Care Act. Last year in this subcommittee and the Health Subcommittee and the full committee, the majority held 12 hearings on the Affordable Care Act.

The hearings last year often were frustrating because they were not held necessarily to examine exactly what the law is doing or to work in a bipartisan fashion to improve the law. They were part of an effort to criticize the Affordable Care Act, spread misinformation and build support for repeal of the Affordable Care Act. The majority's unrelenting focus on repealing the Affordable Care Act is one of the reasons I believe why this Congress has been one of the most least productive in the history of our country.

But fortunately, we are at a different place today. As of today, approximately 10 million Americans have coverage because of the Affordable Care Act. Over two million have coverage through private plans sold through the marketplaces. More than four million have enrolled in Medicaid and now have access to a doctor or health services that they did not have before. More than three million young adults age 26 and under have coverage through their parents' plans, and millions more have coverage purchased directly from an insurer. Now, as Ranking Member DeGette explained, the rollout of Healthcare.gov was anything but smooth, and I directly expressed my displeasure to President Obama and Secretary Sebelius. People were relying on us, and moving forward, and I know there will still be hurdles to overcome over the next few

months but the law is working. Members who want to repeal the Affordable Care Act will have to explain to these 10 million Americans why they should lose their coverage and their new rights and their protections, and coming from the State of Florida, they are going to have to explain to my older neighbors, our parents and grandparents, why they want to take away the improvements in Medicare: closing of the donut hole, the new preventive care and wellness visits that are available and the fact that we made Medicare stronger.

The members will have to explain to the 129 million Americans with preexisting conditions why they do not deserve the same access to health coverage as everyone else. They will have to explain to American women why they want to go back to a world where they could be charged more for the same coverage as a man, and they will have to explain to people who work in blue-collar jobs why they should face higher premiums, and they will have to explain to the millions of Americans getting coverage for the first time why they would be better off uninsured. I do not think my Republican colleagues will be able to make this case.

Mr. Chairman, Republican critics of the law were also incorrect about many things but they were right about one major fact, that once the Affordable Care Act went into effect, there would be no turning back. This law is in effect and it will continue to become a part of the fabric of this Nation. It will lift millions of American families, provide economic security. The Civil Rights Act, the Social Security Act, the original Medicare legislation, all landmark laws, were enormously contentious in their time. Republican opponents predicted they would put this Nation on the path to ruin. They said the Nation was not ready for the changes that were coming. They said the new rights and protections the laws guaranteed for our fellow Americans were not important. And now we cannot imagine our country without a basic safety net for our seniors or equal rights for all of our citizens.

In the years ahead, all the hyperventilating about broken Web sites, enrollment trajectories and demographic mix will quickly be forgotten. Instead, we will look back and wonder how we ever had a health system that spent double what every other Nation spends per capita while leaving 50 million uninsured and allowing rampant discrimination against the people who needed the coverage most.

I hope this hearing will be the start of a productive and cooperative session of Congress, and I hope we can start to work together on the ACA rather than spending another year in a never-ending campaign against a law that is doing enormous good for the American people.

I yield back. Thank you.

Mr. MURPHY. The gentlelady yields back, so I would now like to introduce the witness for today's hearing. Gary Cohen is the Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services. He has served as General Counsel for the California Health Benefit Exchange and has served as the Director of the Division of Insurance Oversight in CCIIO for 2 years prior to

becoming the Deputy Administrator and Director of CCIIO, and I will now swear in the witness.

Mr. Cohen, you are aware that the committee is holding an investigative hearing, and when doing so, we have the practice of taking testimony under oath. Do you have any objection to testifying under oath? Thank you.

The Chair then advises you that under the rules of the House, you are entitled to be advised by counsel. Do you desire to be advised by counsel? In that case, we will swear you in.

[Witness sworn.]

Mr. MURPHY. You are now under oath and subject to the penalties set forth in Title XVIII, Section 1001 of the United States Code. You may now give a 5-minute summary of your written statement, Mr. Cohen.

TESTIMONY OF GARY COHEN, DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Mr. COHEN. Thank you. Good morning, Chairman Murphy, Ranking Member DeGette and members of the subcommittee. I appreciate the opportunity to update you on the Affordable Care Act and health insurance marketplaces and to talk about the millions of Americans who many for the first time are able to purchase high-quality affordable health coverage.

When I appeared before this subcommittee shortly before the beginning of enrollment, I said that while we may encounter some bumps when open enrollment began, we would solve them. Clearly, the problems we encountered in October were far worse than I or any of us anticipated. Simply put, the system did not work nearly as well as it should have or that we expected that it would.

This wasn't a time to get discouraged. It wasn't a time to give up. It was a time to roll up our sleeves and get to work and solve the problems, and that is what we did.

Since that time, we have fixed Healthcare.gov piece by piece in a prioritized, metrics-driven manner. The tech team fixed the site's software and enhanced the site's hardware to improve its capacity, speed and stability. By the end of November, Healthcare.gov was able to support more than 800,000 consumer visits per day with a response time of less than 1 second and an error rate well below 1 percent.

Consumers have responded overwhelmingly to the improved site. Enrollments in the federal marketplace in December alone represent a sevenfold increase over October and November combined. By the end of December, nearly 2.2 million people had selected plans from the State and federal marketplaces.

Sometimes we lose sight when we talk about numbers that are this big, that these enrollments are more than just numbers. They are individual people, many of whom have not been able to obtain needed care or had the peace of mind that comes from having health coverage for years.

For example, Nathan Aldridge, a cancer survivor from Virginia, now has a plan without having to worry about paying more because of his preexisting condition. He had been playing for a plan

with a $483 monthly premium and a $5,000 deductible. Now he has a plan with a $111 monthly premium and a $1,750 deductible.

Emily Wright, a university student in Tennessee, enrolled through the federal exchange, qualified for a federal subsidy and picked a top-tier plan that will cost her only $125 a month. She has been able to get an appointment with an obstetrics/gynecology practice, the first step before needed surgery.

We hear stories like theirs every day. Because of the Affordable Care Act, Americans like Nathan and Emily can be confident that the plans offered in the marketplace are high quality and affordable.

The Affordable Care Act standardizes certain essential benefits which insurers must offer. These include basics like doctor's visits, hospitalizations, prescription drugs, and maternity and newborn care. Marketplace plans are designed so that consumers can compare plans with similar levels of coverage and make more informed decisions.

Insurers are now prohibited from charging higher premiums to enrollees because of their health problems and from charging women more than men, making price more fair. At the same time, premium tax credits and cost-sharing reductions are helping consumers pay for their health care coverage. Of the nearly 2.2 million marketplace sign-ups so far, nearly 80 percent of those consumers are receiving financial assistance.

Insurers can no longer refuse to accept consumers because of a preexisting health condition. With limited exceptions, plans are required to enroll individuals regardless of health status, age, gender or other factors.

Finally, insurance coverage is there when people most need it because plans can no longer impose annual or lifetime dollar limits on essential health benefits. Americans no longer have to worry about hitting a prohibitive dollar amount which could force a consumer into bankruptcy or cause them to have to forego necessary care.

The health insurance market in 2014 looks dramatically different than it did in the years before the Affordable Care Act. Now, as with any change this major, there is bound to be some disruption, so to ease the transition to the new market, CMS is working closely with insurers, consumers and other key stakeholders who are working together to ensure that consumers have coverage and receive needed medical care.

In December, CMS announced a number of steps to help consumers including requiring insurers to accept payment through December 31, 2013, for coverage beginning January 1 and giving consumers additional days to sign up for marketplace coverage. Insurers have also stepped up with many agreeing to voluntarily extend the deadline for consumers to pay their first month's premium, and many pharmacies announced plans to ensure a smooth transition by providing consumers with transitional supplies of prescriptions.

I continue to believe what I said in September: the ultimate story of the Affordable Care Act will not be what happened in the early days that the Web site went live or even in the first days of January as people used their new coverage. The lasting legacy will be people like Nathan and Emily who will be able to get the health

care they need and have the security of knowing they will be able to pay for it because of the changes made by the law.

Thank you, and I welcome your questions.

[The prepared statement of Mr. Cohen follows:]

STATEMENT OF

GARY COHEN, J.D.

DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT,
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

THE AFFORDABLE CARE ACT IN 2014

BEFORE THE

U. S. HOUSE COMMITTEE ON ENERGY & COMMERCE
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

JANUARY 16, 2014

U.S. House Committee on Energy & Commerce,
Subcommittee on Oversight & Investigations
The Affordable Care Act in 2014
January 16, 2014

Good morning, Chairman Murphy, Ranking Member DeGette, and members of the Subcommittee. Thank you for the opportunity to speak about our work implementing the Affordable Care Act to put in place strong consumer protections, provide new coverage options, and give Americans additional tools to make informed choices about their health insurance. Thanks to the consumer protections and insurance market reforms in the Affordable Care Act, millions of people have already obtained coverage, and millions more will have the peace of mind that the coverage they have cannot easily be taken away.

In March 2010, President Obama signed the Affordable Care Act into law, putting in place comprehensive reforms to improve access to affordable, quality health insurance for all Americans and protect consumers from abusive insurance company practices. Over the past three years, Americans have benefitted from insurance reforms that have already gone into effect, such as allowing adult children up to age 26 to stay on their parent's insurance, eliminating lifetime dollar limits on essential health benefits, and prohibiting rescissions of insurance when someone gets sick. Now, in 2014, discrimination by insurance companies against individuals with pre-existing conditions is banned for nearly all individuals of all ages, and consumers have better access to comprehensive, affordable coverage.

What We Have Already Achieved: Better Access to High Quality Coverage

The Centers for Medicare & Medicaid Services (CMS) has implemented strong consumer protections that hold insurance companies more accountable, give consumers more coverage options, and improve the value of that coverage. While the initial consumer experience on HealthCare.gov did not live up to our expectations or the expectations of the American people, those technical issues have now largely been addressed. Since the beginning of open enrollment

in October 2013, over 6 million individuals[1] have enrolled in private health insurance, Medicaid, or the Children's Health Insurance Program (CHIP)—many for the very first time—thanks to the Affordable Care Act. Both state and Federal Marketplaces saw a surge in the number of Americans enrolling in health plans in December, and enrollment in December was five times that of October and November combined. Halfway through a six-month open enrollment period, it is evident that there is strong demand for health coverage and millions of Americans will now have access to quality, affordable health coverage.

Shopping in the Health Insurance Marketplace

Already, millions of individuals have experienced a new way to shop for health coverage through the Marketplace created by the Affordable Care Act. By enrolling in private health insurance through the Marketplace, consumers effectively become part of a statewide group that spreads risk between sick people and healthy people so the costs of care are more equitably distributed. Because of enhanced competition, insurers are now eager for new business, and have created new health care plans with more choices.

The Marketplace makes it possible for eligible consumers to use a streamlined application to apply for coverage through a qualified health plan, to qualify for a premium tax credit and reduced cost sharing, or to determine eligibility for coverage through Medicaid or CHIP.[2] The Marketplace makes it easier than ever before to compare available qualified health plans based on price, benefits and services, and quality. In addition to the Marketplace website, HealthCare.gov, which is the site for most states, consumers can also apply by phone through a toll-free call center, by mail with a paper application, or in person with a trained counselor in their community, to choose health coverage that best fits their needs. Additionally, where permitted by the state,[3] licensed agents and brokers, as well as online brokers, may help consumers and employers enroll in a qualified health plan through the Marketplace.

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[1] http://www.hhs.gov/healthcare/facts/blog/2013/12/nationwide-enrollment-surges.html
[2] Application Elements: http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10440.html
[3] Per 45 CFR 155.220

Consumer interest in gaining health coverage is strong among Americans who currently lack insurance—63 percent say they are likely to get health insurance in 2014.[4] Additionally, interest in the Marketplace is strong and growing. A majority of adults (63 percent) who are potentially eligible to enroll in coverage through a qualified health plan or Medicaid said they were aware of the Marketplace as a place where they might shop for coverage.[5] Twenty-four percent of those potentially eligible reported that they had visited the Marketplace to shop for a plan by December, whether online, by phone, in person, or by mail, up from 17 percent in October.[6]

By pooling consumers, reducing transaction costs, and increasing transparency and competition, Marketplace plans tend to be more efficient and competitive than consumers' previous options. Further, enrollment data shows that despite initial technical challenges, the Marketplace is enabling individuals to successfully enroll in health insurance coverage. Nearly 2.2 million people have enrolled in a private health insurance plan through the Federal and State-based Marketplaces since October 1st,[7] and in October and November, 3.9 million individuals learned they are eligible for coverage through Medicaid and CHIP.[8,9] We expect these numbers to continue to grow through the end of March, when open enrollment ends.

Guaranteed Core Benefits and Comparison Shopping

One reason consumers can be confident about the quality of the plans offered in the Marketplace is that the Affordable Care Act standardizes certain benefits most insurers must offer. Most non-grandfathered plans in the individual and small group markets now cover essential health benefits,[10] which include items and services in ten statutory categories, such as ambulatory patient services (including doctors' visits), hospitalization, prescription drugs, and maternity and newborn care. These benefits must be equal in scope to a typical employer health plan. To this end, the essential health benefits are defined in each state by reference to a benchmark plan. As

[4] Gallup daily polling results, December 3, 2013.
[5] Sara R. Collins et. al., *The Commonwealth Fund,* Americans' Experiences in the Health Insurance Marketplaces: Results from the First Three Months, January 2014.
[6] Sara R. Collins et. al., *The Commonwealth Fund,* Americans' Experiences in the Health Insurance Marketplaces: Results from the First Three Months, January 2014.
[7] http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib_2014jan_enrollment.pdf
[8] These numbers include new eligibility determinations and some Medicaid and CHIP renewals.
[9] http://www.hhs.gov/healthcare/facts/blog/2013/12/nationwide-enrollment-surges.html
[10] Essential Health Benefits: http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/html/2012-28362.htm

a result, consumers are now able to select an insurance plan with confidence that it will cover key health care services when they need them.

Beginning this year, most non-grandfathered health plans in the individual and small group markets also must meet certain actuarial values: 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. Actuarial value means the percentage of the total allowed costs of benefits paid by a health plan on average. For example, if a plan has an actuarial value of 70 percent, the average consumer would be responsible for 30 percent of the costs of the essential health benefits the plan covers. These tiers allow consumers to compare plans with similar levels of coverage, which, along with comparing premiums, cost-sharing provisions, provider participation, and other factors, will help consumers make more informed decisions.

More Affordable Coverage

The market reforms of the Affordable Care Act are also working to make health insurance pricing more fair and to provide tax credits and cost-sharing reductions for eligible individuals, resulting in coverage that is more affordable. New rules prohibit most health insurance companies from charging higher premiums to certain enrollees because of their current or past health problems. Women can get a plan for the same price as men. Most plans are limited in how much more they can charge older individuals than younger individuals. These changes stand in stark contrast to health insurance pricing before the Affordable Care Act, when women could be charged more for individual insurance policies simply because of their gender, and when premium rates charged to older individuals could be five times or more the rate for younger individuals.

At the same time that insurance prices have become more fair, many individuals also have new help paying for their health care coverage through premium tax credits and cost sharing reductions. Many middle and low-income individuals are eligible for a new kind of tax credit that can be used right away to lower monthly premiums for coverage through the Marketplace. The tax credit is sent directly to the insurance company and applied to the premiums, so consumers pay less out of their own pockets. The amount of the tax credit for which an eligible

individual qualifies depends on the individual's household income. Individuals are eligible for premium tax credits if, among other things, they:

- Are not eligible for other affordable health insurance coverage designated as "minimum essential coverage" (*e.g.,* government-sponsored coverage or employer-sponsored coverage); and
- Have modified adjusted gross household incomes between 100 percent and 400 percent of the Federal poverty level (*e.g.,* $23,550 to $94,200 for a family of four in 2013).

Many people can now buy more comprehensive coverage often with lower out-of-pocket costs than they previously paid. Additionally, young adults and certain other people for whom coverage would otherwise be unaffordable or who are transitioning away from their old health insurance plan may enroll in catastrophic plans, which have lower premiums, protect against high out-of-pocket costs, and cover recommended preventive services without cost sharing—providing additional affordable coverage options.

Significant Steps to End to Pre-Existing Condition Discrimination and Limits on Care

The Affordable Care Act has provided consumers with more protections than ever before. As many as 129 million non-elderly Americans have some type of pre-existing health condition.[11] Pre-existing health conditions range from life-threatening illnesses such as cancer, to chronic conditions such as diabetes, asthma, or heart disease.

In the past, health insurers in most states could refuse to accept anyone for individual-market policies because of a pre-existing health condition, or in the group market they could limit benefits for that condition. Now, the Affordable Care Act provides consumers with the security that their coverage will be there for them when they need it. Non-grandfathered health insurers in the individual and small group markets will generally no longer be able to use health status to determine eligibility, benefits, or premiums. New plans in the individual market are required to enroll individuals, regardless of health status, age, gender, or other factors and will be prohibited from refusing to renew coverage because an individual becomes sick. Additionally, insurance

[11] ASPE Report: At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans http://aspe.hhs.gov/health/reports/2012/pre-existing/index.shtml

companies cannot drop or rescind people's coverage because they made an unintentional mistake on their application.[12]

The Affordable Care Act's market reforms also make changes to insurance coverage so it is there when people need it most. Before the Affordable Care Act, some people with cancer or other chronic illnesses could run out of insurance coverage when their health care expenses reached a dollar limit imposed by their insurance policy or group health plan. Now, most group health insurance plans and non-grandfathered individual health insurance policies are prohibited from imposing annual or lifetime dollar limits on essential health benefits. This change will help ensure that consumers will no longer have to worry about hitting a dollar ceiling on their benefits, which could force them to pay out of pocket for health care costs above the dollar limit, forgo necessary care, or even declare bankruptcy – a potentially life-saving change made by the Affordable Care Act.

We have implemented additional consumer protections such as establishing a set of uniform standards for external review of individual health plan decisions restricting an enrollee's access to benefits. Now, consumers enrolled in most non-grandfathered group health plans and individual health insurance policies can ask for an independent third party review of decisions made by their plans and insurance companies to deny coverage of a service.

Easing the Transition to a New Health Insurance Market

CMS is working closely with insurers to ease consumers' transition to health plans with new protections, benefits, and coverage. In December, CMS announced additional steps to help ensure that consumers who are seeking health insurance through the Marketplace transition to coverage that best fits their needs. In the interim final rule (IFR) issued on December 12, 2013,[13] CMS finalized that insurers must accept payment through at least December 31, 2013 for coverage beginning January 1, 2014, and that individuals had until December 23, 2013 (an extra eight days) to sign up for Marketplace health insurance coverage beginning January 1, 2014. In addition, CMS separately urged several steps on the part of insurers to ease consumers' transition

[12] For an example see: http://www.healthcare.gov/law/features/rights/cancellations/index.html
[13] http://www.ofr.gov/OFRUpload/OFRData/2013-29918_PI.pdf

to new coverage, including giving consumers additional time to pay their first month's premium for coverage beginning January 1, 2014, treating out-of-network providers as in-network to ensure continuity of care for acute episodes or if the provider was listed in the plan's provider directory when the consumer enrolled, and covering prescriptions covered under previous plans during the month of January.

Many stakeholders have responded positively and are working together to smooth this transition and help ensure consumers have coverage and receive needed medical care. On December 18, 2013, America's Health Insurance Plans' Board of Directors announced that health plans would voluntarily extend the deadline for consumers to pay their first month's premium, accepting payment through January, 10, 2014 for coverage retroactive to January 1, 2014. In addition, several pharmacies, including CVS, Walgreens, Kroger, Rite Aid, and numerous community pharmacies, announced plans to furnish consumers with transitional supplies of prescriptions if needed.

CMS continues to work closely with consumers and other key stakeholders to ease the transition into 2014. For example, CMS is working with consumers to make sure that they know whether their doctor or prescriptions are covered before they choose a plan, and providing consumer tips on how to get care during the transition. Additionally, CMS continues to reach out to consumers who experienced technical difficulties when applying for coverage through the Marketplace to ensure their opportunity to enroll.

Conclusion

CMS has worked hard since the enactment of the Affordable Care Act to improve the health insurance market for all Americans. We are proud to see many of the Affordable Care Act's key market reforms now in place, and while more work remains, we are encouraged that those who already have health insurance will have better, more reliable coverage, that families will not be denied coverage because of a pre-existing condition, and that more than 6 million individuals have been enrolled in Marketplace, Medicaid, or CHIP coverage. We look forward to continuing our efforts to strengthen health coverage options with the help of our partners in Congress, state

leaders, consumers, and other stakeholders across the country. Thank you for the opportunity to discuss the work that CMS has been doing to implement the Affordable Care Act.

Mr. MURPHY. I thank the gentleman. The chairman now recognizes himself for 5 minutes.

Mr. Cohen, you testified several times before this committee that HHS would be ready by October 1. Can you tell us why you were wrong on that?

Mr. COHEN. When I testified, Mr. Chair, you referred to April and in September, and each time I gave you the best information that I had and gave you truthful testimony based on the information that I had available to me. It turned out that the problems that we faced when the Web site went live were, as I have said and as everyone knows, just dramatically different and bigger than I think what any of us expected.

As to why we didn't anticipate what was going to happen when we went live, I am not sure I know all the answers. I think some of the people who are responsible for designing and building the Web site might be able to give you better answers. I know initially we were overwhelmed by the volume of people who came in, but as time went by, that was clearly not the sole source of the problem. There were other problems as well.

Mr. MURPHY. But you were there for the briefings, the McKinsey report, which we discussed in this subcommittee, the disaster that they talked about to a number of people within the Administration, so you had that information, but you also said you were told something otherwise. So who told you otherwise that things would be fine?

Mr. COHEN. So may I speak for a moment to McKinsey? I absolutely attended briefings of the work that the McKinsey folks did, and there is no question that they identified a number of risks that they saw back in April, whether we would be successful come October. At no time did the McKinsey people say to us, you are not going to make it or you are not going to be successful. They identified a series of risks and they identified some steps that they recommended we take in order to mitigate those risks and increase the likelihood that we would be successful, and I think we did those things, and I think that a number of the concerns that McKinsey expressed, for example, whether the hub would be working or whether some of the larger States like New York and California would succeed did not prove to be a problem. The hub has worked very well, and New York and California have done very well.

So I think we took very much to heart what the McKinsey people recommended that we do and we proceeded forward and tried to, you know, do the best we could to maximize the likelihood that we would be successful.

Mr. MURPHY. But again, we have looked at the McKinsey report. It was not subtle. It was strongly worded in terms of there were serious problems, but in that same month you came before us and said things were fine, so who on your staff told you that things were going to be OK? Who informed you specifically?

Mr. COHEN. I received regular briefings from the various parts of CMS that were responsible for——

Mr. MURPHY. Who was it?

Mr. COHEN [continuing]. Overseeing the Web site build. The person that I heard from the most probably was Henry Chao.

Mr. MURPHY. And Henry Chao told you that despite the briefing from McKinsey that things would be OK?

Mr. COHEN. Henry Chao gave—we had regular reports on the status of the build, and certainly when I came here in September, the testimony that I gave was based on briefings that I had from Mr. Chao and others as to what the capability of the site——

Mr. MURPHY. Did you share with Mr. Chao the McKinsey briefing?

Mr. COHEN. I don't know whether he saw the briefing itself.

Mr. MURPHY. Did you discuss the contents of that with him?

Mr. COHEN. I think we talked about the issues that were raised in the briefing, yes.

Mr. MURPHY. See, I am puzzled, because when Mr. Chao was here speaking under oath, he said he didn't know anything about it.

Mr. COHEN. That is why I say I don't know that we told him or whether he saw the report itself—but we talked about the issues——

Mr. MURPHY. So let me ask this. It was significant enough that the Secretary said that she hired McKinsey to give them a briefing and look at this analysis. Very important, significant problems were identified. They were not small. But now we are not sure whether or not the key person who was advising you of this was even told about this report to identify and what to do about the major problems. So there is something pretty inconsistent here.

Mr. COHEN. Well, I think that we adopted a number of the recommendations that McKinsey had for us and put into place a number of things that McKinsey recommended that we do in order to increase the likelihood of our success, and that is what I mean. Those things happen. So Mr. Cao was aware of the things——

Mr. MURPHY. Well, I need to know what specifically, if you go to the doctor and the doctor says can you tell me what your specific symptoms and problems are, if you don't tell the doctor what your problems are, they can't properly diagnose and treat. So what specifically did you tell Mr. Chao and what specifically then did he do in response to that?

Mr. COHEN. I am not going to be able to recall or tell you exactly what we told Mr. Chao. What I can tell you is that there were recommendations, for example, in the report with respect to how we should be organized and some changes that they recommended that we make in terms of how the process was managed that we implemented as a result of the report.

Mr. MURPHY. Thank you.

I recognize Ms. DeGette for 5 minutes.

Ms. DEGETTE. Thank you very much, Mr. Chairman.

This hearing today, I just noticed this after my opening statement, is called "2014: Seeking PPACA Answers." So I would really like to ask you, Mr. Cohen, some questions about where we go from here.

As you acknowledged in your opening statement and your written statement, the problems with Healthcare.gov were far greater than ones you anticipated before October 1st, and we are now well aware of the Administration's efforts to fix the problems. I am wondering if you can tell me as we sit here today, January 16th, what

problems do you still see with the federal Web site and what steps is the Administration taking to remedy them?

Mr. COHEN. Thank you. We continue to address specific issues with respect to the way that the site is functioning, and that effort has not flagged at all. I mean, it is ongoing. So as we continue to identify any aspects in the way that the system isn't performing as properly as it should, whether those be design and architecture or whether those be software, sort of coding types of problems that were not getting the right result, we continue to address a lot of those issues. The major one that we are dealing with right now I would say in terms of big picture has to do with the financial management making sure that the plans are getting paid. We are using a mitigating process right now because we don't have full functionality for that particular process but we are working to put that in place.

Ms. DEGETTE. As we heard in November and December, the Administration was focusing first on getting people enrolled and then they were worrying about the back end. So with that back end, what kind of problems are we still seeing and what are you doing to try to remedy that?

Mr. COHEN. Well, right now, payments will be going out next week for the first time of advanced premium tax credits to issuers but we are using a process where they are providing us with the data from the issuers based on their records as opposed to being able to use the records that are generated by the FFM, and that more automated process will be going into place in the next months.

Ms. DEGETTE. And are you working, is the Administration working with the insurers to make that happen?

Mr. COHEN. Yes, absolutely, and we have actually had tremendous responsiveness from the insurers and they have told us that they are very pleased with the way that process is going. It is not ideal but it will work to get them paid.

Ms. DEGETTE. Mr. Chairman, I think that would be a good follow-up hearing to bring the insurers in and see how that is working, just FYI.

Let me ask you, Mr. Cohen, we have all heard about the number of people who have signed up both on the State exchanges in the States like mine that have State exchanges and also Healthcare.gov. What is your opinion about the number of people who have signed up and also the age mix?

Mr. COHEN. So in terms of the number of people who have signed up, obviously there is no question that we got off to a slower start than we would have liked and than what we hoped but we had tremendous response in December and we are continuing to see very good numbers as we go into January. I think in terms of the total if we are able to maintain the pace that we are at now and if we see another, you know, sort of uptick towards the end of March as everyone expects because that is the deadline for the end of open enrollment, we still have almost 3 months to go so I think we are very encouraged by the enrollments that we are seeing now. There clearly is tremendous demand for this product. We saw that from the beginning.

Ms. DEGETTE. But there is also—I will say, though, because of the glitches with the Web site in the early days, enrollment has been lower than the Administration had projected, correct?

Mr. COHEN. That is true.

Ms. DEGETTE. And what about enrollment of younger people?

Mr. COHEN. So, you know, we are actually quite encouraged by the response that we have gotten from younger people. The percentage of younger people that we reported this week is actually comparable to the percent of that age group in the general population so I think that is looking good. I think——

Ms. DEGETTE. If you could just—I am sorry. If you can just briefly tell me what the Administration is doing to bump those numbers back up between now and the end of March both for the general population and also for the younger enrollees.

Mr. COHEN. Absolutely. So, I think you are going to see a stepped-up media campaign. Obviously we as well as the health insurance companies held back a little bit in the beginning because the site was working well, but now that it is, I think we will see a significant increase in that. It is going to be very much targeted at the younger audience so we have a Magic Johnson ad that is coming out now. We are going to be advertising during the Olympics. You know, we are trying to advertise in ways that will—and through social media as well, ways that are definitely targeted toward that younger group.

Ms. DEGETTE. Thank you very much.

Thank you, Mr. Chairman.

Mr. MURPHY. You may want to talk to Jimmy Kimmel because he is not saying good things about this.

Ms. DEGETTE. We can also have ads during the Super Bowl because I know that will appeal to the Colorado voters.

Mr. MURPHY. That will be costly. There you go.

I now recognize Dr. Burgess for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman, and Mr. Cohen, you know I am going to bring this up. I have got to do it. I need to have you address it.

September 19, 2013, I asked you a yes or no question, will the enrollment process be ready October 1 of this year. I will remind you of your answer. You said, "consumers will be able to go online. They will be able to get a determination of what tax subsidies they are eligible for. They will be able to look at the plans that are available where they live. They will be able to see the premium net of subsidy that they would have to pay, and they will be able to choose a plan and get enrolled in coverage beginning October 1st." Do you recall that exchange, sir?

Mr. COHEN. I recall it very well.

Mr. BURGESS. Knowing what you know now, would you like to revise that answer in any way?

Mr. COHEN. Well, clearly, it was wrong, but it was also what I believed and what I understood——

Mr. BURGESS. I have got to——

Mr. COHEN [continuing]. Based on what I had been told. I would like to answer your question, if you would permit me.

I knew that I was going to be asked that question obviously when I came here on September 19th and I knew that it was very

close to October 1st, and I was very careful to get a thorough briefing from the people who are responsible for overseeing the build of the Web site, and the answer that I gave you was exactly what they told me our functionality would be on October 1st, exactly.

Mr. BURGESS. Who told you that exactly?

Mr. COHEN. Mr. Chao was in the briefing, among others.

Mr. BURGESS. Well, look, you know, I have just got to tell you this, and you have heard me say it before and I will continue to say it in the future. I simply do not understand why no one has been held accountable for an error that egregious. If I were you, I would fire someone under me, and it would have happened in October. If I were the Secretary, I would have fired you, and that would have happened in October, and if I were the President, I would be so mortified and embarrassed by what has been the disaster of my signature piece of legislation signed into law, I would fire the whole lot of you.

Now, that was the tack not taken——

Mr. COHEN. But if that had happened——

Mr. BURGESS. I would like to understand why should we believe you now when nothing you said over the past year, year and a half has been accurate?

Mr. COHEN. Because the site is working, Congressman. Because the site is working. That is why you should believe me now.

Mr. BURGESS. I would submit——

Mr. COHEN. And if we had all been fired, it would not be working.

Mr. BURGESS [continuing]. It is not working because it has not been built on the back end. Provider payments are not flowing. The subsidies that are supposed to go to the insurance companies, they tell me are coming as a result of a paper process that is having to be entered by hand. This thing is a disaster, and the providers are going to be the ones who take it on the chin because we are obligated to see those patients when they show up. No one can verify benefits at 3 o'clock in the morning. You take care of the problem after the fact. Who pays the bill? The Secretary said she would not be responsible for paying those bills, so I ask you, doctors and hospitals around this country are asking you, who is responsible for paying those bills?

Mr. COHEN. The insurance company——

Mr. BURGESS. You haven't built the back end of the Web site.

Mr. COHEN. The insurance company that has enrolled a person is responsible for paying those bills, and the payments of the tax credits and cost-sharing reductions to those insurance companies will be flowing next week. They will begin next week. That is going to happen.

Mr. BURGESS. And I would submit to you that part of the Web site has not yet been built and that is going by hand and is a painfully slow process. I have been told numbers as low as 5 to 10 percent of those payments are going through. I would appreciate if you have additional information that you will make it available to the committee. I hope we will have an opportunity to discuss that in the future.

Mr. COHEN. Absolutely.

Mr. BURGESS. As it does concern me a lot. I think our providers are the ones who are truly at risk from your mismanagement of this problem.

Now, there is something that is receiving a lot of attention right now. It is the concept of risk corridors and risk adjustment. Are you aware of that?

Mr. COHEN. Yes.

Mr. BURGESS. The risk corridor program does not contain specific appropriation in the law, so are you going to be seeking an appropriation for the risk corridor language in the law?

Mr. COHEN. I am going to have to refer you to the Office of Management and Budget with respect to those issues.

Mr. BURGESS. Would you be willing to share with us the ongoing discussions that are happening between you and OMB on that? Are there e-mails? Are there memos? Is there information you can make available to the committee?

Mr. COHEN. I will certainly take that request back.

Mr. BURGESS. It appears to a lot of us that you are going to be needing and sending taxpayer dollars in order to handle this problem of the risk corridors. Can you assure the committee today that that will not be happening, that this risk adjustment will be done from within the balances available in the Affordable Care Act and those amounts that you are collecting from insurance companies and not come from the taxpayer?

Mr. COHEN. I don't have an answer for you today. I understand it is an issue. We are working with OMB and I will certainly work with you and understand that it is an important issue that you are entitled to know about.

Mr. BURGESS. If you have a legal memorandum that has been prepared for you or your department, will you share that with the committee?

Mr. COHEN. That is not a decision I get to make but I will certainly take your request back. I haven't seen such a memorandum myself, no.

Mr. BURGESS. You have not?

Mr. COHEN. At this point, no.

Mr. BURGESS. Do you anticipate seeing one?

Mr. COHEN. I don't know the answer to that.

Mr. BURGESS. This committee needs that memo, and I want you to take that request back with you. Again, we will have an opportunity to talk again, I believe.

I yield back, Mr. Chairman.

Mr. MURPHY. Thank you.

Mr. Cohen, I want to give you an opportunity to answer one of Dr. Burgess's questions. Has the part of the Web site dealing with payments been built or is it yet to be built?

Mr. COHEN. The automated process for payments is still being built but we have a process in place that is working and payments will be going out next week.

Mr. MURPHY. Do you have an anticipated date of when it is going to be built?

Mr. COHEN. I don't have an answer to that as I sit here, no.

Mr. MURPHY. Thank you.

Ms. DEGETTE. Mr. Chairman, could we have him supplement that when he finds out when it will be built?

Mr. MURPHY. Yes, we would like to know that.

Ms. Castor, you are recognized for 5 minutes.

Ms. CASTOR. Thank you, Mr. Chairman. Good morning, Mr. Cohen.

You know, the headline back home in Florida this week was, Florida enrollment surges under Healthcare.gov during October and November. Due to the problems with the Web site, we only had 18,000 Floridians sign up for coverage. But in December, we had 140,000 Floridians sign up for coverage. Florida continues to lead the Nation in enrollment among the three dozen States that are using the federal marketplace. So this is good news. In fact, on Monday in Tampa, the mayor of Tampa, Bob Buckhorn, had a great announcement, and this is something that other Members of Congress can use and work on with their elected officials. Mayor Buckhorn announced that all of the parks and recreation centers in the city of Tampa would be available to host navigators and assisters sign up many of our neighbors for coverage. I think this is a very creative move. Secretary Sebelius gave him a pat on the back as well.

We have got to make it easy for folks to sign up, and one of the things that is, I guess, a good problem to have is, we have such a competitive marketplace in the Tampa Bay area, we have over 100 private insurance plans that people can examine and see what works best for them. But, you know, that can be a little daunting for folks as well if they just go on to—I guess there are people that can go on to Healthcare.gov and figure it out and analyze it and determine what works best for them but there are many, many people all across the country that need to sit down and work with a real person and sort through those options, understand what the tax credits do. In Florida, two-thirds of those who are eligible for coverage will be eligible for the tax credits. Already, over 80 percent of the people who have signed up have used those tax credits.

What can we do to get more help out on the ground to help people understand the options?

Mr. COHEN. So thank you, Congresswoman. I think it is very important, as you say, to get support from State and local officials from Congressional offices to help get the word out, to direct people to assisters who can help them. There is a Find Local Help section of Healthcare.gov where people can say, you know, what area they are in and get a list of the——

Ms. CASTOR. But many people, if they don't have a computer, they don't even know about that.

Mr. COHEN. Right.

Ms. CASTOR. So how are you going to reach them?

Mr. COHEN. For the people who don't have a computer, obviously the effort really has to be to bring them in to a location where, you know, a navigator is working or, you know, other assisters are available to help them through the process, and I think, you know, the more assistance that we can get from people in the community who know these folks rather than, you know, just coming from the Federal Government is a big help.

Ms. CASTOR. Our community health centers have been very active, churches. It is really a community-wide effort. But I appreciated that you said talking about the millions of folks who have signed up that these are not just numbers, these are real people, and really, one of the biggest obstacles right now for many of our neighbors to realize health care coverage is what Republican governors and State legislators have done in blocking the Medicaid expansion. For example, in the State of Florida, we have almost one million Floridians who are caught, are being blocked, access to the doctor's office is being blocked just because they won't accept the $50 billion available to the State of Florida over the next 10 years. That is our tax money. We want that tax money back to work for our neighbors to help our families get to the doctor's office, create jobs, help our hospitals.

Mr. Chairman, I think we need an oversight hearing on these States that have blocked Medicaid expansion and what that is going to do to the health care marketplace.

Mr. Cohen, what is HHS's plan to continue to work with the States on this issue?

Mr. COHEN. We certainly encourage every state to take up the Medicaid expansion. It is a great deal for the state. It is a great deal for the people in the state. It is a great deal for providers in the state who will see a decrease in uncompensated care, a tax that falls on all of us, and we have been working as creatively as we can with different States to come up with different ways of doing this. Some States have some different approaches that they wanted to take that we have been working with them on, so we continue to work with all the States and hope that more will take up the expansion.

Ms. CASTOR. Thank you very much.

Mr. MURPHY. The gentlewoman yields back. Now the vice chair of the full committee, Ms. Blackburn, for 5 minutes.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

Mr. Cohen, you just said that your testimony to Mr. Burgess on September 19th was incorrect and you had based it on staff reports. Am I correct in that?

Mr. COHEN. I said it turned out to be wrong.

Mrs. BLACKBURN. Turned out to be wrong.

Mr. COHEN. It turned out to be wrong.

Mrs. BLACKBURN. Let me ask you this then. If you are basing your testimony today on staff reports, how do we know that this is correct?

Mr. COHEN. I think that there has been an intense focus since October on——

Mrs. BLACKBURN. Have you changed your process of due diligence? Are you vetting? Are you questioning?

Mr. COHEN. I think we are receiving more and more thorough briefings at the leadership level.

Mrs. BLACKBURN. How do you know that? If what you told us on September 19th was wrong, how do you know that what you are telling us right now is correct?

Mr. COHEN. Well, ultimately, I have to rely on the people who work for me. I don't——

Mrs. BLACKBURN. You didn't fire anybody then. Are you watching it more closely now?

Mr. COHEN. I think we are having regular and very detailed briefings on——

Mrs. BLACKBURN. OK.

Mr. COHEN. And we also brought in what we sort of call the general contractor, the QSSI company that was an existing contractor on the project.

Mrs. BLACKBURN. Do you want to quantify those briefings for us as you submit things about the Web site and when it is going to be due? Why don't you let us know what briefings you are having?

Also, I want to ask you one thing real fast. You said the Web site is fixed. Can you define "fixed?""

Mr. COHEN. I think the Web site is fixed in the sense that we are no longer having problems that we had creating accounts in the beginning. The responsiveness of the site——

Mrs. BLACKBURN. So it is not 100 percent operational, it is a qualified fix?

Mr. COHEN. That is true.

Mrs. BLACKBURN. OK. So it is fixed as an amoeba, and that is going to change as you come back to us.

Let me move on. You had three promises in Obamacare. It was built on three promises. It was going to save families $2,500 a year, and the second two promises, one, if you like your plan, you can keep it, and if you like your doctor, you can keep it. So let me ask you this. Since the President promised that the average family would reap a premium decrease of $2,400 a year under the law, has that happened?

Mr. COHEN. Well, I am not sure that is what the President said.

Mrs. BLACKBURN. Yes or no. Oh, yes, he did say it.

Mr. COHEN. I am not sure that is what the President said.

Mrs. BLACKBURN. Yes, sir, he did say that.

Mr. COHEN. Many Americans are able to obtain better coverage at lower costs than——

Mrs. BLACKBURN. Mr. Cohen, that is not what the President said, and I ask for a yes or no answer.

Let me move on. The President said if you like your plan, you can keep it. Has he kept that promise?

Mr. COHEN. The law permitted insurance companies to maintain grandfathered plans in effect. That was their decision whether to continue with those plans or to——

Mrs. BLACKBURN. No, sir, that was not the promise. The President even apologized for this, and he offered some enforcement relief so that these people could keep the plans they liked. Is that correct?

Mr. COHEN. I was about to say that not all Americans were able to keep their plans because of the decisions that the industry had made, and so we announced a transitional policy that enabled more of the plans to stay in effect.

Mrs. BLACKBURN. How long will that transitional process last? A year, 2 years, forever?

Mr. COHEN. As of now, what we have announced so far is it is for a year.

Mrs. BLACKBURN. You know, a lot of those people couldn't keep their plans, and you talked about an Emily from Tennessee. Let me tell you about another Emily from Tennessee. Emily lives in Pulaski. Emily had coverage because Emily has lupus, and guess what? Under Obamacare, her plan was canceled. Emily doesn't have health insurance right now. She is having a tough time getting it under Obamacare. I am having her in as my guest for the State of the Union. Maybe you can help Emily work this out, Mr. Cohen, because your promises that were made by you and this Administration have not been kept, and then you want to give us a qualified definition of "fixed" and you are still depending on your staff, so you all are just running in circles, and you cannot give us definitive answers.

So let me ask you this. Emily in Pulaski, she had a doctor she liked. Is she going to be able to keep that doctor even though she has no insurance and because of Obamacare her insurance was canceled and she is trying to be treated for lupus and work 40 hours a week?

Mr. COHEN. You know, if you will get us information about—if Emily is, you know, interested in talking to somebody from CMS who can help her understand what her options are——

Mrs. BLACKBURN. I appreciate that very much.

Mr. COHEN. We would be happy to do that. We are doing——

Mrs. BLACKBURN. Because she is a classic victim of what has happened when the Federal Government stepped in and said all these plans that you have that work for you, that fit for you, we are not going to let you keep them because we the Federal Government think we know better how you, Emily, can handle your lupus. Now, that is what you have done to the American people, and when you come in here, you give us misinformation, and then when we ask you a question, you cannot be specific.

Mr. Cohen, I agree with Dr. Burgess. You ought to be fired.

Mr. MURPHY. The gentlelady's time is expired. I recognize now the gentleman from Vermont, Mr. Welch, for 5 minutes.

Mr. WELCH. Thank you, Mr. Chairman.

Mr. Cohen, there are a lot of things in the Affordable Care Act but many of those provisions are about consumer protections to ensure that Americans do have a diverse choice of health care providers. But as with many new laws, there are some wrinkles in the implementation and some disagreement between—debate about Congressional intent, and I wanted to ask you about one of those with respect to the ACA.

I have been hearing from some providers, and I know some of my colleagues have been hearing the same concerns about the interpretation of the provider non-discrimination provision in Section 2706 of the Public Health Service Act, and specifically, what some of these providers are telling me is that your agency's sub regulatory guidance, in their view and in the view of many legislators, is inconsistent with the statute and legislative intent, and the concern is this, that the guidance could lead in fact to discrimination against some providers by health insurers, which this provision was designed to prevent. Are you aware of these concerns? And my question is, what are your plans to address them and to ensure that the statute is implemented as intended?

Mr. COHEN. So thank you, Congressman, and yes, I am aware of those concerns. I have had meetings with a number of provider groups who have expressed the concern that you have raised. Frankly, it has been a while since we looked at that issue so what I would ask is that we could have folks talk to you and your staff and move forward to understanding what the concerns are and seeing whether there is something we can do to clarify the guidance so that we make sure that there isn't discrimination, which clearly is what the law——

Mr. WELCH. Well, that would be helpful, and there may be some colleagues on the other side of the aisle as well who are hearing some of these concerns, so I would welcome the opportunity to follow up with your agency and try to work this out to make certain that we stay on that intent that there not be discrimination as to providers.

Mr. COHEN. We would be happy to do that.

Mr. WELCH. Thank you. And just a couple of things. You know, one of my concerns from the very beginning is, we have got to get health care costs down. I don't care how we pay for it, whether it is employer based, taxpayer based, individual based. If the cost is going up a lot faster than wages, profit and growth, we are just not going to have a sustainable and affordable system, and what we are learning now is that Medicare spending is growing slower than the inflation rate. This is recently, and that is a welcome development, that the program spent only .7 percent more per beneficiary in 2012 than in 2011. Five years ago, that annual increase was 5.4 percent. Overall, just an overall global health care spending, the rate of increase has slowed. It was 3.7 percent in 2012, less than half of the growth year a year ago. Two questions. One, do you attribute any of this to the law? And number two, what are the implications for the deficit over a 10- to 20-year period?

Mr. COHEN. So I think that the law does contain a number of provisions that are attacking the question of health care costs. I think that that is an issue that we need to continue to work on, and I think that the law does give us some tools to continue to do that. I look forward to using our process of certifying qualified health plans going forward. We were quite liberal, I guess is the word I would use. We sort of took them all the first year to get the market up and running, but I think going forward we can at least look at what we can do to encourage health insurance companies to work to keep costs down, and certainly, you know, we know that health expense is a huge part that the American economy and the Federal Government spends so as we are able to attack that problem, it will have a great positive impact on spending and the deficit going forward.

Mr. WELCH. Yield back.

Mr. MURPHY. The gentleman yields back. I now recognize Dr. Gingrey for 5 minutes.

Mr. GINGREY. Mr. Cohen, thank you for being with us once again. I asked you the last time you were here whether you had concerns that young people would not sign up for Obamacare and would cause an increase in cost to the rest of the risk pool in the following years. You responded that your research—this is a quote—"research shows that most people want health care and the

barrier has been the cost," and that you are looking forward to people, including young people, enroll in coverage.

With the latest figures showing that young people are enrolling at a much lower rate than you had originally anticipated, are you now worried, are you still worried that premiums will increase next year, that it is not just the natural tendency for young people, indeed, for all of us to procrastinate that there are some other concerns such as maybe these overwhelming number of mandates which we knew 10 years ago were driving up the costs of healthcare insurance in the individual States, probably all 50 States, including mine of Georgia. We knew these age banding rules that were put in Obamacare rather than, say, five to one maximum premium increase for older people compared to younger is now three to one. Community ratings, these things are there, and I am real concerned. Do you continue to be concerned about that?

Mr. COHEN. Well, we certainly want to do everything we can to encourage all Americans and in particular young Americans to get health care. I think it is important to keep in mind that the risk pool is not just the risk pool in the marketplaces, the risk pool is in the entire market, and so when you have, say, three million young people who have been able to get health coverage on their parents' plans, those are not necessarily in the marketplace but those are three million young Americans who didn't have insurance before who do have insurance and are part of the risk pool.

I also would just point to a recent study by the Kaiser Family Foundation, which actually said that a reduction in the percentage of people, young people who come into the risk pool really will have an impact on health care premiums that is pretty modest.

Mr. GINGREY. Of course, some of that is anecdotal. I understand what you are saying.

But let me move to my next question. You know, I am concerned, I have heard that navigators are actually going door to door, and this came up last time too, and you said that navigators would not be going door to door. They are. And if you recall during that same hearing, you told us, this subcommittee, that you would be "issuing instructions to navigators that they should not be going door to door." Did you issue these instructions?

Mr. COHEN. Yes, we have, and if you are aware of instances where navigators who are, our grantees are going door to door, we certainly want to hear about those.

Mr. GINGREY. Well, I thank you, because I am aware, and I would like to ask staff to put up a brief clip of a video right now in regard to that since you asked me to show you some evidence.

[Video shown.]

Mr. GINGREY. OK. That is good.

Mr. Cohen, what do you say to that?

Mr. COHEN. I had not seen that before, and we will look into it. Thank you for calling it to our attention.

Mr. GINGREY. Well, I hope you will look into it. I mean, some of my colleagues, we are very strong in saying that you should be fired. I don't know. My dad told me one time when I was in college and my grades came in and they weren't so good, and I said Dad, I am doing the best I can, and he said son, unfortunately, your best

just isn't good enough. I am not calling for you to be fired but we are concerned. You have a big job. You have got a huge responsibility, and you know that and we know that, and back to the drawing board, you have got to do better, absolutely.

With that, Mr. Chairman, I yield back.

Mr. MURPHY. Mr. Yarmuth, you are recognized for 5 minutes.

Mr. YARMUTH. Thank you, Mr. Chairman.

Mr. Cohen, welcome back, and it is good to see you again. I would like to start off by getting something clarified for the record. This relates to Ms. Blackburn's questioning. It is my recollection that what the President said was that after the Affordable Care Act was implemented, that insurance premiums, people would save $2,400 a year as opposed to what they would have been spending, compared to what they would have been spending if it weren't for the passage of the Affordable Care Act. Is that your recollection of what he had said?

Mr. COHEN. That is my understanding of what he said, yes.

Mr. YARMUTH. Not that people's insurance would cost $2,400 less?

Mr. COHEN. That is my understanding, correct.

Mr. YARMUTH. And in fact, as has been alluded to earlier in the various questioning, health care costs are rising at a much lower rate than they have historically. So while the numbers may not be precise, there is evidence to suggest that the President was actually correct in that insurance would have cost more if it weren't for the Affordable Care Act.

Mr. COHEN. I think there is no question about that, and I think it is also true that many Americans are seeing actual reductions in what they are paying over what they were paying, not every American but many Americans are.

Mr. YARMUTH. Right. Let us talk about the enrollment history because, first of all, it gives me an opportunity to boast about my State, Kentucky, which is widely recognized as having had one of the most successful rollouts of the Affordable Care Act. Currently, the numbers are, in a State of 4.4 million people, 778,000 visitors to Kynect, our Web site, 123,000 plus have enrolled in either Medicaid or private plans. Five hundred and fifty-nine thousand Kentuckians have been screened to determine whether they were eligible for either Medicaid or subsidies under private insurance, and many of those have not yet selected their plan, even though they have been told that they qualify for private insurance, and 1,283 small businesses—this is as of January 2nd—have started the process to enroll their employees as well. So we are talking about already having insured about 20 percent or more of our entire uninsured population in just over half the—well, this would have been exactly half the enrollment period.

And by the way, 40 percent of those are under 35, so in terms of Kentucky's experience, I think there is reason to be, as you said, optimistic that going forward, we will have adequate numbers of young people in the risk pools and we shouldn't be too concerned yet about that.

But a couple weeks ago, in one of the major national media, there was a chart that actually broke down the enrollments according to three categories of States. They had the 14 States and the

District of Columbia, which had both expanded Medicaid and set up their own exchanges, States that have expanded Medicaid using the federal exchange, and then States that had not expanded Medicaid, and while I didn't do the math, it was pretty clear that at least two-thirds and maybe even 75 percent of all the enrollments, the six million or so enrollments, were in those 14 States plus the District where there was concerted government support for the program.

So I would like you to comment that and whether you are seeing that the degree of enrollment seems to be correlated to the degree of support at the State and local level for the program.

Mr. COHEN. I think that is absolutely right, and it is true for many reasons. Kentucky is a great example where Governor Beshear has been just a stalwart advocate for health care reform and for the Kentucky marketplace and getting it going. I think that contributes to the success that those States have had in terms of developing their marketplace and their IT systems. If the administration in the State is solidly behind that, it helps. It certainly helps with the outreach. It helps with sending out positive messages to people and to the community of how important this is and what a great benefit this is for people, so I think there is no question.

Mr. YARMUTH. Now, we saw video there of navigators going door to door. There is another side of that coin as well, and I know I have talked to some people, for instance, in Florida where they have actually been handing out flyers discouraging people from signing up. Have you seen much evidence that there is a concerted effort to actually discourage people from exploring their options under the exchanges?

Mr. COHEN. You know, I have heard some of that. I wouldn't be able to say how extensive it is. I think obviously it is very unfortunate that anybody would try to discourage people from taking advantage of an opportunity to get health care.

Mr. YARMUTH. Just the last question: Is there any effort in your organization to try to find out or get evidence as to whether that is happening or not? Because that would, I think, be of interest to us.

Mr. COHEN. I don't know that we are investigating that within CCIIO, no.

Mr. YARMUTH. Thank you. I yield back.

Mr. MURPHY. Thank you. I now recognize Mr. Olson for 5 minutes.

Mr. OLSON. I thank the Chair, and welcome, Mr. Cohen. I hope you had an enjoyable holiday season like I did with my family.

Mr. COHEN. Thank you.

Mr. OLSON. My first question is about a thing called the Federally Facilitated Exchange User Fees. Are you familiar with that fee, sir?

Mr. COHEN. Yes.

Mr. OLSON. OK. So as you know, it is a fee that is imposed upon states that have chosen not to create their own health care plan, but to be in the federal health care plan, such as my home State of Texas. This fee is required under the Affordable Care Act?

Mr. COHEN. I think it is authorized by the law, and we set the fee on insurance companies based on the premium that they get in the market.

Mr. OLSON. Would it surprise you that an HHS rule in November of 2012 created and authorized that fee?

Mr. COHEN. Yes, we issued a rule that implemented that provision.

Mr. OLSON. Is it 3.5 percent?

Mr. COHEN. Yes.

Mr. OLSON. Is the Administration fully using that fee? Or do the plans and States have to cover some slack?

Mr. COHEN. I don't believe that the amount of that fee will fully cover the cost of operating the Federally Facilitated Marketplace. I don't think it is going to be enough to pay all of the costs of running the marketplace.

Mr. OLSON. So you are tapping the resources of the private sector, the States to pay the shortfall from this fee that is not getting the job done, correct?

Mr. COHEN. No, no. We are tapping resources from within our budget, but the fee is the fee.

Mr. OLSON. OK. And the fee is authorized for one year. Do you expect to extend it next year?

Mr. COHEN. Yes, I expect there will be a fee next year.

Mr. OLSON. OK. My second line of questions are about the navigators, and as you know, that video from my colleague, Mr. Gingrey, was pretty damning. You may recall when you were here September 19th when I asked you about the navigators back home in Texas, that there was voter registration cards going door to door, and you said, and this is a quote, about the navigators: "We will be issuing instructions to navigators that they should not be going door to door."

My question is, and I'm serious. Have you issued those instructions? Yes or no.

Mr. COHEN. Yes.

Mr. OLSON. Can we get a copy of those instructions?

Mr. COHEN. I am sorry?

Mr. OLSON. May we get a copy of those instructions so we can see them?

Mr. COHEN. Sure. I can go back and tell you how we communicated that. I know we have regular communications with the navigators and we put out that information to them, that that was something that they were not supposed to go door to door to enroll people. They could drop off information but they were not supposed to go door to door to enroll people.

Mr. OLSON. We have heard stories from New York and Florida and the New York Times that people, about all the fraud that is coming out with these navigators. What has CCIIO done to address these fraud cases and make sure fraud doesn't happen? Because it is a big window of opportunity for people who want to do harm.

Mr. COHEN. Any situation that we have learned about that involves any misconduct by a navigator, we have responded to. We have—including requiring individuals that were involved to be dismissed and not to serve as navigators, and including issuing correc-

tive action plans to any navigator organizations that if we feel that they are not supervising their employees adequately.

Mr. OLSON. My final question is about the disastrous rollout of Obamacare and its continued problems. Delays and misinformation are happening today all over America. For example, I enrolled in the D.C. exchange shop, as did my staff. My wife called up last week trying to make sure we could keep this one doctor we like, a specialist. It took her 30 minutes to talk to somebody on the phone, and she was asked to read her new information. She got her new Care First card there, read it proudly, and they said, we have no record of that. So she had to get the old card and work through this agency to be confirmed that yes, we could keep that doctor on our plan.

And so my question is, given this disastrous rollout and the continued problems, have you ever been part of a conversation, debate, or discussion about delaying the launch or putting a hold on it while dealing with all these problems? Any discussions? Have you ever been part of that?

Mr. COHEN. No.

Mr. OLSON. No. OK. I yield back the balance of my time. Thank you.

Mr. MURPHY. Thank you. Mr. Green, you are recognized for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman, and again, welcome back, Mr. Cohen. I was shocked to see the news report in New Orleans, because in Houston, our navigators do not go out and go door to door. We do have nonprofits that are not federally funded who are going in, and I am encouraging them to come into our district to go out and let folks know they have this ability to do it, but the federal navigators we have, now, they will come out to someone's house but it will be a request or because they need to somebody to help with the family or something. So I am glad you are going to investigate that happening because I want navigators actually helping people do the paperwork.

As one who supported the Affordable Care Act and continues to, we need the law, and I would love our committee to be able to work on it and fix some of the flaws that we have in that we have discovered, but I am pleased with the enrollment increases in the last few weeks. HHS released them earlier this week, and we know that nearly 2.2 million have signed up for the private insurance plans through the federal and State marketplaces as of December 28th. Four million more were signed up for Medicaid, and let us not forget that three million adults under 26 are still being able to get insurance through their parents.

Do these enrollment estimates sound accurate to you that we received?

Mr. COHEN. Oh yes, I am sure they are as accurate as we can make them.

Mr. GREEN. They are not as much as we would like, and I know the Administration, but I have a memo from my Democratic staff on our committee that puts these numbers in context. Enrollment in the Affordable Care Act exchanges is ahead of the Part D enrollment at a similar time in 2006. Republicans then called Part D a success. Now they insist the Affordable Care Act is a failure. We

still have a lot more work to do in the months ahead but there is no doubt that a lot of people are finding access to quality, affordable health care. I hope my Republican colleagues will sit down and work on legislation that will fix some of the problems we have because nothing Congress ever passes is perfect, and we know that, and particularly with this. Instead of just throwing rotten apples, maybe they should look back on what happened in 2003 when we passed the prescription drug plan that I didn't vote for but I was also helping my seniors sign up for it and encouraging people to do it, even though I thought the law was flawed in 2003. Some of it has been fixed by the Affordable Care Act but it has—we want to make sure those folks get it, and that is what amazes me.

Mr. Cohen, based on Massachusetts' experience with implementing health reform, what would you expect enrollment numbers to look like over the next few months?

Mr. COHEN. I think we are very encouraged by what we saw in December. I think we are encouraged by the tremendous interest that there remains in the plan. Clearly, Americans are now very much aware of Healthcare.gov as a result of what has happened over the last few months, and I think everyone expects that as we move toward the—we still have 2 ½ months left to the open enrollment period and I think everyone expects as we get towards the end of March when it is the real deadline, we will see another real uptick in the number of people enrolling, and if that happens, I think we will have some very good total enrollment numbers by the end of the period.

Mr. GREEN. Well, we know that in the federal exchanges, seven times the amount of people signed up in December as did in October and November. Frankly, part of it is because of the Web site, and a lot of have concerns because that Web site was down. We did an event in Houston in the middle of November and we actually had about 800 paper applications, and we had plenty of applications—I know there was an issue—we had paper applications both in Spanish and English that were used. But that is not the way we can get to the numbers we need. The Web site has to work.

Finally, can you talk about outreach plans the Administration has in place to ensure that as many people as possible learn about the signup for the new health coverage during the remainder of the enrollment period?

Mr. COHEN. I think we will be seeing significantly more paid media. I know there is a plan, as I mentioned, to advertise during the Olympics and other events that are particularly geared toward younger people, sporting events and those kinds of things. I know the social media activities are very much picking up, and I think from what I am hearing, we are going to be seeing very significant investment by the private health plans in marketing and advertising as well. A number of them sort of held back because of the issues early on with the Web site, but now that they see the enrollments are coming through, I think we will see significant investment on outreach on their part as well.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. MURPHY. The Chair now recognizes Mr. Griffith for 5 minutes.

Mr. GRIFFITH. Thank you, Mr. Chairman.

Mr. Cohen, thank you for being here. In your responses to Ms. Blackburn, you indicated that many Americans have better plans at a lower cost. Do you recall indicating that to her?

Mr. COHEN. Yes.

Mr. GRIFFITH. Under oath and in your sworn——

Mr. COHEN. Yes. Many Americans have better coverage than what they had before and it is costing them less. I think I mentioned at least one of them in my oral testimony.

Mr. GRIFFITH. Yes, you did, and you actually mentioned a couple, one of them from my district, and I understand that.

Also, you would have to acknowledge under oath that many Americans have lesser coverage at a greater cost. Isn't that true?

Mr. COHEN. No, that is not what I said. What I said was——

Mr. GRIFFITH. It isn't what you said. I am asking——

Mr. COHEN. For some——

Mr. GRIFFITH. Yes or no. I am asking you a question under oath.

Mr. COHEN. I don't believe——

Mr. GRIFFITH. Do you know that many Americans have lesser coverage under the Affordable Care Act at a greater cost than they had before? Isn't that true?

Mr. COHEN. No, I don't know that.

Mr. GRIFFITH. You don't know that? Well, let me tell you, I received an email today from a constituent of mine who I know very well. His premiums in March are going to triple, and his deductible is doubling. That is lesser coverage at a greater cost. So there is one.

I will tell you that I have received numerous communications from members of my district, people who live in my district, along those lines and yes, there are some winners but there are also many losers, and it shocks me that you cannot acknowledge that here today when you are testifying under oath in front of this committee. There are losers under Obamacare, aren't there?

Mr. COHEN. Can I answer?

Mr. GRIFFITH. Well, it is a yes or no. You know that there are losers under Obamacare, do you not?

Mr. COHEN. If I am not allowed to answer, then——

Mr. GRIFFITH. The answer is either, yes, you know that there are losers, or no, you don't know that there are losers. It is a yes or no, sir.

Mr. BUTTERFIELD. Will the gentleman yield?

Mr. GRIFFITH. I will not yield. The witness is not being responsive.

Mr. BUTTERFIELD. I think you need to define "losers."

Mr. GRIFFITH. A loser is one who has to pay more for coverage that is lesser, and I just gave him an example but he won't acknowledge that he knows of anybody in the—do you know of anybody in the United States in that circumstance, sir? Yes or no.

Mr. COHEN. I am sure there is somebody in the United States in that circumstance, yes.

Mr. GRIFFITH. And do you acknowledge that you have read the reports on other people who have had some successes who are winners under this, you have also read reports in the media of people who are losers under Obamacare, have you not?

Mr. COHEN. The problem that I have, Congressman, is that I don't know what all the options are that might be available to that person. So it is difficult for me to answer without knowing the full situation of what might be available to that person. I understand that there are people who had coverage and received a notification from their insurance company that they were being put into a different plan that costs more. Absolutely that has happened.

Mr. GRIFFITH. And you have reason to believe that those people are paying more and receiving lesser coverage?

Mr. COHEN. Well, I don't know the details of what the plan is that they were in, what the details of the plan is that they were being offered, and I don't know the details of what other plans might be available to them that might enable them to avoid that situation. So I think it is a little more complex than you are presenting it to me and that is all.

Mr. GRIFFITH. Well, and I would submit that it is more complex on all of these situations because we have a 2,000-some-page bill that is very hard for people to get their arms around and it is very hard for this Administration apparently to operate and to run.

That being said, let us talk about the SHOP exchanges for small businesses. That is another part of the plan that has been delayed for a year. Is that correct?

Mr. COHEN. The online capability for SHOP is delayed for a year, yes.

Mr. GRIFFITH. And many of the other delays were for a few weeks or months. Why was this program delayed for a year?

Mr. COHEN. Given everything that we needed to do to get the system working well for people in the individual market, we made a decision that in terms of allocation of resources, we couldn't get the SHOP online functionality built in time for this year and so we are relying on the traditional agents and brokers who historically have always been the way that——

Mr. GRIFFITH. It was a complicated situation that you had a hard time getting your arms around, and maybe if you sat down and learned all the aspects of it you could advise——

Mr. COHEN. No, we had to make a choice. We had to decide what to devote our resources to.

Mr. GRIFFITH. I was being sarcastic. I apologize.

Mr. COHEN. I know you were.

Mr. GRIFFITH. Here is my problem, and this happens so often with this. The delay was announced the day before Thanksgiving, wasn't it?

Mr. COHEN. I believe you. I don't remember but I believe you.

Mr. GRIFFITH. OK. Do you know if there were conversations before that day before Thanksgiving announcement? How long in advance was the decision made to delay the SHOP plan?

Mr. COHEN. I am sure that there were conversations before it was announced. I wouldn't be able to tell you exactly when but I know that into November there were conversations, and then a decision was made and then it was announced.

Mr. GRIFFITH. There is a great concern for a lot of us that a lot of these announcements come—we have even made comments in other hearings that these announcements come at holidays so that people will be doing other things and won't pay attention to the

fact that there has yet been another delay, another failure in the rollout of this program.

Do you agree that that is not an appropriate way to run the operation and it really ought to be coming out when people can know what is going on instead of during the holiday time when nobody is paying attention?

Mr. COHEN. Well, I would agree with you that it is very important that we put out accurate information so that people could understand what is happening with the program, yes.

Mr. MURPHY. The gentleman's time is expired. I now recognize Mr. Tonko for 5 minutes.

Mr. TONKO. Thank you, Mr. Chair, and thank you, Director Cohen, for your testimony once again before the subcommittee. I believe we should have civil discourse with you, and so I will try to conduct myself accordingly.

Before I get to my questions, I just wanted to share with the committee an Obamacare success story that I recently received from a constituent. Brian from the city of Schenectady wrote to me that he had been paying almost $360 per month for a plan with no dental or vision coverage. Through New York State's online exchange, he was able to get a comparable medical plan and also purchase dental coverage for $290 per month. As he described it to me, this is more coverage for less money. Brian was able to complete the process in less than 2 hours, and because he makes only $11 per hour, the difference in premiums is having a huge impact on his budget. Brian is not alone. As of January 1, more than 241,522 New Yorkers were now enrolled in quality, low-cost health insurance coverage through my home State's exchange.

In addition, more than 6,500 young adults in my district now have health insurance through their parents' plan, and more than 12,100 seniors in the district receive prescription drug discounts worth $16 million. One hundred and twenty-four thousand seniors in the district are now eligible for Medicare preventive services without paying any copays, coinsurance or deductibles. I could go on and on but the point is that the Affordable Care Act is here to stay and it is providing an enormous benefit already to the people of the 20th Congressional District of New York, which I have the good fortune of representing.

It never ceases to amaze me how hard my Republican colleagues work to avoid acknowledging the benefits of ACA. I have never heard them admit that this law helps the millions of Americans with preexisting conditions who can no longer be discriminated against.

Mr. Cohen, can you summarize for us some of the important new protections that are now in place under the Affordable Care Act?

Mr. COHEN. Well, certainly. Thank you, Congressman. Absolutely, the issue of preexisting is a huge one. Previously, people could be denied insurance altogether, not even because they are sick at the time they are applying but because they had some condition in the past that caused the medical underwriters to say that they weren't a good risk, and then if they were offered insurance, notwithstanding whatever that preexisting condition might be, they could be charged significantly more as a result of that, and one of the impacts of that, of course, was the fact that women were being

charged, you know, substantially more than men—being a woman was deemed to be a preexisting condition. So all of that is gone.

And then the last one I would mention, and I think it is very important, is that in the past, people could find that if they did become seriously ill, their insurance would run out because they had either an annual limit of how much it would pay or a lifetime limit of how much it would pay, and they might be in the middle of a course of treatment that was necessary to save their lives and find that all of a sudden the insurance companies stopped paying and that they were responsible for those costs on their own, and that can't happen anymore.

Mr. TONKO. Thank you. The stories of people signing up for coverage would drive home how important these new provisions are, and I know some stories have recently been posted. I read a story about Nick from Miami. He is 29 and was denied coverage last year because of a preexisting condition. He was forced to enroll in a short-term catastrophic plan that cost him $280 a month and had a termination date. Because of the ACA, he now has better coverage with lower out-of-pocket costs and a guarantee that he won't be kicked off his coverage or denied because of a preexisting condition. Now he is covered and he does not have to worry. There are more of these stories each and every day.

Albert from Texas got covered for the first time in his life because of the ACA. He got a plan for only $23 per month. He said it is the right thing to do. You never know what could happen to you.

Mr. Cohen, have you heard other stories like these?

Mr. COHEN. Yes, we are hearing stories like that all the time, and we are seeing them through social media. We are seeing people are sending us their stories. On Healthcare.gov there is a place where you can provide your story, and I must say they are extremely heartening.

Mr. TONKO. And what do they say to you about the importance of the Affordable Care Act?

Mr. COHEN. The Affordable Care Act is literally going to be lifesaving for many, many, many Americans who without it would not have had the ability to get the health care that they need and it is going to be a financial lifesaver for many Americans who otherwise would have faced bankruptcy as a result of medical costs, which was the leading cause of bankruptcy in the country prior to the ACA and I think we are going to see that change dramatically.

Mr. TONKO. I just wish our colleagues would just admit for even the briefest moment that this law is helping millions of people. Maybe then we could move forward and have a national conversation about the Affordable Care Act and any additional improvements that might be required. So with that, I thank you, Director Cohen, and thank you for appearing before our committee.

Mr. MURPHY. The gentleman yields back. I now go to Mr. Long of Missouri for 5 minutes.

Mr. LONG. Thank you, Mr. Chairman.

One person that does not think this is a lifesaving endeavor is Brenda from my district, and Brenda has been fighting a very rare form of cancer for the last 7 years, and she leaves Springfield, Missouri, to go down to Little Rock, Arkansas, to seek treatment. She

is in a high-risk pool. She was in a high-risk pool. When she found insurance, she found out that she could no longer go to Little Rock, Arkansas, to seek treatment from this very specialized doctor that has literally kept her alive for the last 7 years. They gave her 3 months to live when first diagnosed. She got active. She is mid-50s, late 50s, and back then she was early 50s, I guess, 50 years old, and she decided it wasn't time to die so she wanted to fight and get active and find a treatment for this, so she did down in Little Rock, Arkansas, and she called me from her chemo chair or texted me, emailed me from her chemo chair telling me that she had lost her insurance, and when she found new insurance, because the high-risk pool is going away, when she found new insurance, she was told that she could no longer seek treatment down in Little Rock, Arkansas, from this doctor, who is one of the few in the country that does it. So I know you say it is lifesaving. I know that my friend from New York says that he wants people on this side of the aisle to admit there are good cases. Sure, there is people that are picking up insurance, there are good cases, but there is also people that this could very easily cost them their life. So I am concerned for people like Brenda.

Mr. COHEN. Well, we certainly would like to hear from you about Brenda's situation, if there is anything we can do to work with the insurance companies.

Mr. LONG. And I appreciate that.

Mr. COHEN. We would be very happy to do that.

Mr. LONG. I gave a floor speech on the subject a month or so ago, whenever she first emailed me, and she was literally in the chemo chair in Little Rock taking the treatment, and she said all the nurses stood up and cheered for my floor speech in the room, but there are serious concerns for people like Brenda.

Sticking with the high-risk pools for just a minute, I know that this new national high-risk pool as opposed to the State-run ones that ran out at the end of December or whatever have been extended to the end of what period?

Mr. COHEN. End of March.

Mr. LONG. End of March. How are those being paid for? I mean, where are you getting the money to pay for those? Who is paying for that? We cannot get any answers, at least my staff has been able to, on how this is being funded.

Mr. COHEN. Oh, that is very clear. I mean, there is a $5 billion appropriation in the Affordable Care Act, and that is the entire amount of money, that $5 billion appropriation that was in the Affordable Care Act that has paid for the PCIP program, and we had——

Mr. LONG. I hate to interrupt you, that is not my style, but the $5 billion, wasn't that for a set amount of time? But we keep getting these extensions that don't seem to be paid for.

Mr. COHEN. So the statute says that we can use that money to ease the transition of PCIP enrollees into the new market and so what we found was, we had enough funding based on the number of enrollees we had and the costs that we are incurring to allow those benefits to continue through March, and at the end of March—by the end of March, everyone who is in that program needs to get private coverage, and that program——

Mr. LONG. Or they won't be able to seek care in Little Rock. That is the rub there, I think.

The ranking member said earlier, and my friend from Florida made reference to the fact that there is all these people that have enrolled in the Affordable Care Act that didn't have coverage before. How can we drill down and figure out what the number is? Just because 146,000 in Florida in Ms. Castor's district signed up in December, how do we know that those people did not have insurance before? How do we know they are not like Brenda that was forced off her plan and hopefully can find another plan? Is there a way to ascertain if these are true numbers, if these are really people that are covered for the first time ever, they now have health care insurance that never had it before?

Mr. COHEN. So that is a really good question, and we are working on being able to provide data as to the number who were previously uninsured versus the number who may have been insured before and are switching to new coverage, and we understand that is an important issue. We don't have that data today.

Mr. LONG. If you can work on that, because one side tells one side of the story, one side tells the other, and usually, as you know, the truth lies in the middle. So when I hear how many people that never had cover before, I question if they didn't have it, lost it and bought new.

So thank you for your time here today.

Mr. COHEN. Thank you.

Mr. MURPHY. The gentleman yields back. Now Mr. Butterfield for 5 minutes.

Mr. BUTTERFIELD. Thank you, Mr. Chairman, and thank you, Mr. Cohen, for your testimony today. I want to assure you, Mr. Cohen, that when the history of this debate is written many years from now, I promise that you will be regarded as one of many people in this Administration and across this country who were on the right side and helped millions of Americans get insurance. You are doing the right thing, and I want to thank you for what you do.

Mr. COHEN. Thank you.

Mr. BUTTERFIELD. But Mr. Chairman, this is getting ridiculous. My friends just won't let go. I think Mr. Tonko made reference to it a few minutes ago.

Let me try to put this in somewhat of context. Yesterday's New York Times wrote that North Carolina Senator Kay Hagan has faced more than 3,500 negative ads about the Affordable Care Act since June 1st. That amount of negative ads is more than three times as much as any other Member of Congress. Five million dollars has already been spent on negative ads related to Obamacare in my State of North Carolina.

The fact is, Mr. Chairman, the Affordable Care Act is the law of the land. It is working in my State. A vendor in my district is named Carlton Stevens, Jr. I drove up to an Exxon station a few days ago, and Little Carlton, we call him, jumped out his car and told me how excited he was that he had signed up with the Affordable Care Act, told me that he was paying $700 for he and his wife and two children, that the premium was going up to $800, that he enrolled in the Affordable Care Act and is now paying $240 per month.

The fact is, and the reason Mr. Cohen had difficulty in trying to describe winners and losers is that each case is unique. You have to compare the coverage. You have to compare the cost. You have to compare the circumstances. And so the vendor in my district is Carlton Stevens and he is getting insurance now for $240 per month.

Of all states participating in the federal exchange, my state, Ms. Ellmers' state as well, had more than 107,000 enrollees from October to December, which constitutes the most enrollees in the federal marketplace per capita. Eighty-nine percent of those enrollees are low or middle income and qualify for a tax credit for their plans. North Carolinians are having tremendous success with the federal marketplace and Healthcare.gov. In fact, North Carolina leads all other States in Health and Human Services Region 4 with more than 61 percent of individuals who complete an application selecting a marketplace plan.

Nationwide, the trend is very similar. By the end of December, nearly 2.2 million had enrolled and several hundred thousand more have enrolled since then. Tuesday's Washington Post cover story stated, "The data show a sevenfold upswing in enrollment in the federal exchange from the first 2 months as the Web site's performance improved."

And so Mr. Cohen, I want to ask you, can you describe for me the trend in the number of adults 18–34 who have selected these marketplace plans?

Mr. COHEN. I think we reported the 18–34 was about 24 percent of the enrollments and that that was very close to the percentage of that age group in the general population, so we were quite pleased by that, and we expect to see that number increasing as we move through the rest of the open enrollment period.

Mr. BUTTERFIELD. Well, talk to me about some of the national campaigns which will help to begin to get youth enrollment up higher than even 24 percent, perhaps to 40 percent.

Mr. COHEN. So I know that we are going to be doing a lot more paid media, specifically around the Olympics, which will be starting in a couple of weeks, and around other sporting events and other activities that we would expect young people to be particularly interested in. I know we have been doing and are doing an increased amount of outreach through the social media, Facebook, Twitter, all that sort of thing, and I know that all of our advertising is very targeted to try to reach the populations that we most want to get—obviously we want everyone to enroll but we want to particularly focus obviously on the young people, as we have talked about.

Mr. BUTTERFIELD. Thank you. And lastly, I made reference to my home State of North Carolina in my introductory statement, and I am very proud of the enrollment rates there. I have 700,000 people in my congressional district, and I tell you that 100,000 of those 700,000 are uninsured, and this is making a difference. What factors do you believe contribute to North Carolinians choosing marketplace plans at such a high rate as compared to the national norm?

Mr. COHEN. Well, I mean, I have to believe that in places where the need is the most, is where we are seeing the biggest response.

So in places where the rate of uninsured was high, I think that is where we are seeing the biggest response.

Mr. BUTTERFIELD. Thank you.

Mr. MURPHY. In response to his question, do you know how you are spending on the Olympics advertising?

Mr. COHEN. I actually don't but I am sure we can get that for you.

Mr. MURPHY. Please let us know. Thank you.

I now recognize the gentlelady from North Carolina, Ms. Ellmers.

Mrs. ELLMERS. Thank you, Mr. Chairman, and to my colleague from North Carolina, Mr. Butterfield, I am going to extend some of the questions to you, Mr. Cohen, where Mr. Butterfield left off.

Mr. BUTTERFIELD. And adjoining districts, we might add.

Mrs. ELLMERS. Yes.

Mr. BUTTERFIELD. Adjoining districts.

Mrs. ELLMERS. My colleague pointed out that about 107,000 have enrolled in North Carolina. Those are the figures that we are seeing. However, 437,000 received cancellation notices for health care policies they already had. So even though 107,000 may sound impressive, we are way behind on those who have had their policies cancelled. So there is a lot of making up to do.

I do want to get back to some of those numbers. Now, correct me if I am wrong, but how many people in America do you believe have signed up for coverage now?

Mr. COHEN. Well, the most recent figures that we put out were 2.2 million, and that is just in the marketplace. Obviously there are people who are buying coverage——

Mrs. ELLMERS. So the six million figure that I keep hearing about today, where is the six million figure coming from?

Mr. COHEN. That is taking the 2.2 and adding 3.9 million who enrolled in Medicaid.

Mrs. ELLMERS. OK. So basically what we are doing is, we are culminating. Are you aware that the Washington Post gave three Pinocchios to this number? Are you going to keep this figure?

Mr. COHEN. I didn't see the Pinocchios. I would have to take a look at what they called into question.

Mrs. ELLMERS. So you agree with the six million figure? You believe that there have been six million?

Mr. COHEN. I believe that as we reported, 2.2 million have enrolled in marketplace plans and about 3.9 million had enrolled in Medicaid, and I think the Medicaid number was actually only through November.

Mrs. ELLMERS. OK. Now, of those who signed up for Medicaid, how many of them could have previously signed up for Medicaid but did not before Obamacare was instituted?

Mr. COHEN. I don't have that number for you.

Mrs. ELLMERS. You don't have the number? Can you get the number?

Mr. COHEN. I can certainly ask my colleagues in Medicaid if they have that number.

Mrs. ELLMERS. OK. Because that——

Mr. COHEN. I don't run Medicaid so——

Mrs. ELLMERS. That doesn't fall under you?

Mr. COHEN. No.

Mrs. ELLMERS. OK. So now we have a situation where we have a number of Medicaid that are signed up. Wonderful. We want to make sure that people have coverage that is applicable to them, but isn't this going to play into the cost factor, especially for those States, we don't really know where the numbers fall as far as those who could have signed up before, but did not for whatever reason and now have?

Mr. COHEN. Well, the States that expand, the newly eligible will be paid 100 percent by——

Mrs. ELLMERS. Right, the newly eligible, but those who could have received coverage before, the States are going to be responsible for a percentage of that, correct?

Mr. COHEN. That is right, under the usual match, yes.

Mrs. ELLMERS. Now, you said you don't have the number, you don't have the figure, when we had Secretary Kathleen Sebelius, she said that she did not have that number, and I believe she actually said that they could not get that number, so I would appreciate if you could get that to us in the committee, because I think the thing of it is—and I will just quote the Washington post fact checker. Basically what he said is this number tells you almost nothing about how the health care law is affecting Medicaid enrollment. Reporters need to stop using it because basically—and that is a quote—it is very misleading. It is very misleading.

Now, I have got a little bit more time here. We are all sharing stories about our constituents, and some of the stories that we have heard have been positive. I want to hit on the issue of the change for women because I keep hearing about bringing down costs for women. However, I have a woman who was formerly in my district, is not in my district now, from Rocky Mountain, North Carolina, who basically reached out to my office and through a personal situation, lost her health care coverage and now the plan—she was paying $254 a month. Now she is going to have pay $610 a month. She simply cannot afford it. She is probably going to have to choose to not take coverage. How can we continue to claim that health care has improved for women (with mammograms) when we call these things free, how did we go from $254 a month to $610 a month and we can still claim that she is getting free services?

Mr. COHEN. So again, I really can't address an individual's situations without more of the specifics. We would be happy to, you know, have folks talk to her if she is interested.

Mrs. ELLMERS. Well, I would appreciate that. I will have my staff get that information to you and your office so that we can work, because if we are really going to take care of women in this country, health care issues for women, let us be straight on it. Let us make sure that we are getting the points across because women's health is very, very important, and this is very misleading.

So with that, I yield the remainder of my time.

Mr. MURPHY. The gentlelady yields back. I now recognize Ms. Schakowsky for 5 minutes.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

I want to talk a little bit about constituent services when it comes to health care because long before the Affordable Care Act, my office spent a lot of time dealing with insurance problems, people who suddenly weren't able to get the medication that they had

been getting before, I mean, really tricky issues that sometimes we could solve and sometimes we couldn't solve. So the private insurance market as it was before was very difficult to navigate. I think that is really important to remember.

But I have to tell you, Mr. Cohen, we have done constituent service with your office on many occasions now since the Affordable Care Act is in place, and I am happy that you were able to tell my friend, Congressman Long, that you would look at the Brenda situation and work to get her the health care that she needs, and I would suggest that my experience has been that we have been able to resolve through your office many of the problems. Yes, this is a confusing time, but I guarantee you that before Obamacare, it was very confusing every year, and by the way, still is with Medicare Part D, and we really encourage all of our constituents on that program to look every single year to make sure that their medications are still on the formulary.

Mr. COHEN. And if I can just say, Congresswoman, we have gotten tremendous response from the insurance industry, from the pharmaceutical industry as we have tried to resolve these problems this January, and I have talked with the issuers, I have talked with the pharmacies, I have talked with the hospital association, and what I am hearing from them is that the nature of the problems that we are seeing as we moved into January and people using their coverage are no different from what has happened every year as people get new coverage, change coverage. There are always issues in terms of people being able to verify their enrollment, being able to see their doctor, all those kinds of issues, and we stand ready to help. We have caseworkers in every single region of the country, and we stand ready to help anybody if we possibly can.

Ms. SCHAKOWSKY. And I know that in my state, Democrats and Republicans are working very hard to help their constituents and so I am hoping that everyone on the other side of the aisle on this committee is taking advantage of the constituent service that is available from you and then also through the insurance companies and the pharmaceutical companies.

I wanted to again go over a little bit on the issue of these letters of termination. Insurance companies that we have talked to said they expected almost all of their current customers to stay covered. Have you seen evidence of that?

Mr. COHEN. Oh, absolutely. So it really is not accurate to think that because a plan is no longer being offered that that means the person is not getting coverage. Again——

Ms. SCHAKOWSKY. And let us be clear. It is not offered because it doesn't meet the criteria of the——

Mr. COHEN. That is right. So in every instance that I am aware of, the carrier offered the person a new plan that in some cases automatically enrolled them in a new plan so that there would be no gap in coverage. So and then in addition to that, of course, through our transitional policy, we have made it possible for people to keep their existing plan if that is what the insurance company wants to offer to them.

Ms. SCHAKOWSKY. My understanding of this issue of the grandfather option enables about half of those who receive cancellation notices to renew their plan. Has this been happening?

Mr. COHEN. That is right.

Ms. SCHAKOWSKY. And roughly half the remaining group that got cancellation letters, my understanding is, are able to get actually a better deal through the federal and state marketplaces because they are eligible for tax credits or Medicaid, so they get better coverage for a lower and often much lower cost.

Mr. COHEN. So for people who are eligible for the subsidy, absolutely, we would expect that they would pay less and they would in many cases get better benefits than what they had had.

Ms. SCHAKOWSKY. And finally, in December, the President announced that individuals who had canceled policies would be eligible for a hardship exemption so they could purchase low-cost catastrophic plans. How will this change the options available to those that got cancellation notices?

Mr. COHEN. So what that basically means is, anyone who got a cancellation and feels that the plans that are available to them are not affordable can claim the hardship exemption and can enroll in a catastrophic plan, which is a high-deductible plan but will cover them in the case of any serious illness, and those plans are generally very affordable.

Ms. SCHAKOWSKY. Thank you. I yield back.

Mr. MURPHY. The Chair recognizes Mr. Johnson for 5 minutes.

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. Cohen, I too would like to thank you for being here today. You know, we have had a long and arduous journey since this all started and the American people came under the Affordable Care Act back last October, the Web site going up, and you mentioned in your testimony that the problems that we had, that it wasn't time to give up, it was time to roll up our sleeves and get to work. Well, I respect that, but I will submit to you that we have got a little bit of a different idea about what roll up your sleeves means. You see, the American people, businesses, individuals, hardworking taxpayers across this country who are increasingly burdened by the big-spending over-regulating policies of this Administration, not very many of those folks get a second chance. Only in Washington, D.C., and with this Administration do we see a constant pattern of redo at somebody else's expense. In this case, it is the American people's expense.

So I submit to you that what we should have done, what the Administration should have done is roll up its sleeves and do this the right way in the first place. Let doctors and patients manage their health care. We have got a private sector health care system that has provided the best health care in the world. It did not have to be done this way.

Let me get to a few specific questions. Since the launch of Healthcare.gov, Mr. Cohen, has the site been subject to any security breaches?

Mr. COHEN. No.

Mr. JOHNSON. No security breaches?

Mr. COHEN. There have been no breaches in the sense of anybody attacking the site and being able to——

Mr. JOHNSON. There have been no incidences of people attacking——

Mr. COHEN. No, where they were successful.

Mr. JOHNSON. That is what you just said.

Mr. COHEN. Well, because you interrupted me, Congressman. I didn't get a chance to finish what I am trying to say. No, there have been no successful attempts where anyone has been able to attack the system and penetrate it.

Mr. JOHNSON. Wow, that is contrary to what we have heard in other testimony and what is widely known in the media.

Ms. DEGETTE. Mr. Chairman, I respectfully disagree with that.

Mr. JOHNSON. Claiming my time. Claiming my time. What is the difference, in your opinion, between a security incident and a security breach?

Mr. COHEN. You could have a security incident where because of an error or a mistake or somebody sent something to the wrong place, you know, that was an isolated, specific incident where information was transmitted in a way that was incorrect. When I hear breach——

Mr. JOHNSON. How do you relate that back to the testimony that we have heard before the Energy and Commerce Committee that security was never even factored in and tested prior to standing up the Web site? So can you promise the American people today right now that their personal information is secure on Healthcare.gov?

Mr. COHEN. Yes. I can't promise that there won't ever be an incident but I can promise that their information is secure, and I can promise that——

Mr. JOHNSON. That sounds like an oxymoron to me. You can't assure that there is not going to be a breach but their information is secure?

Mr. COHEN. That is not what I said.

Mr. JOHNSON. Let me ask you a follow-on question. Can you promise to this Congress that if Healthcare.gov is subject to a breach or a hack or any security failure that you will alert the Congress as soon as you find out about it?

Mr. COHEN. We follow normal procedures and protocols for when those incidents happen.

Mr. JOHNSON. But the American people need to know and this Congress needs to know, so can we get your agreement that you will notify Congress if that occurs?

Mr. COHEN. We will certainly work with you to make sure you get that information.

Mr. JOHNSON. Whose job is it to inform Congress and the American people when a security breach occurs? Whose job is that?

Mr. COHEN. CMS has an Office of Security, information security, that is responsible for that, and is today in the case of the Medicare system where we have 50 million enrollees whose data——

Mr. JOHNSON. I got it. CMS is responsible. Who is responsible for the overall cyber security of the Healthcare.gov site?

Mr. COHEN. I think that is the same.

Mr. JOHNSON. Do you know how many people in CMS are dedicated to protecting the security of Healthcare.gov?

Mr. COHEN. I couldn't tell you a number of people. I know we have a dedicated security team. I know we do continuous monitoring. We actually have people watching the site 24 hours a day.

Mr. JOHNSON. Do you know how many contractors are involved?

Mr. COHEN. I don't.

Mr. JOHNSON. Do you know how much money is being spent to provide security?

Mr. COHEN. On security? I would have to get that number for you.

Mr. JOHNSON. Does anyone report to you regarding the security of the site?

Mr. COHEN. My office is not responsible for the security of the site but I am given reports——

Mr. JOHNSON. Can you give us examples of those reports so we can see what those reports include?

Mr. COHEN. I can certainly take that request back and see what we have.

Mr. JOHNSON. OK. Well, I mean, they come to you so you ought to be able to release them, right?

Mr. COHEN. I can certainly take your request back and see what we have.

Mr. JOHNSON. Mr. Chairman, I yield back.

Ms. DEGETTE. Mr. Chairman, I ask—oh, go ahead.

Mr. MURPHY. I was just going to say that a number of the reports on attempts to hack into the system are classified, and we can make that available to all members to know that there have been multiple attempts. There has not been a breach yet but I am sure the attempts will continue on, but much of that is classified.

Ms. DEGETTE. Mr. Chairman, in that vein, last week Democratic staff of the subcommittee and full committee prepared a memo of information that was provided in the classified briefings, which is not classified. A lot of the—I was at the classified briefings. A lot of that information was not of a classified nature, and what that information said is, there are no successful hacks of Healthcare.gov, and it further said that surprisingly there have been no additional attempts than other government Web sites. And so I would ask unanimous consent to put that memorandum, which is dated January 9, 2014, into the record.

Mr. MURPHY. And we will take that into the record.

[The information appears at the conclusion of the hearing.]

Mr. MURPHY. We will also remain vigilant, because we suspect there will continue to be attempts.

Now, there is some time left on the floor for votes. We can adjourn to go vote and come back and complete this——

Ms. DEGETTE. I think we have time.

Mr. MURPHY. Would you like to continue? Who is next?

Mr. Harper, you are recognized for 5 minutes.

Mr. HARPER. Thank you, Mr. Cohen. Good to see you again. We are almost done. I would like to ask a few questions if I could.

You touched on earlier in response to some questions about risk corridors.

Mr. COHEN. OK.

Mr. HARPER. And it is a program to offset huge cost increases being the temporary risk corridor program. Where within the Administration is this program housed? Is it HHS, CMS or where?

Mr. COHEN. Risk corridors is under my program.

Mr. HARPER. And the individual in charge of that program would be who?

Mr. COHEN. The person who works for me who is responsible for that program's name is Sharon Arnold.

Mr. HARPER. So it is just that one person then that would be the one in charge?

Mr. COHEN. Well, she runs the program. She reports to me, so I am responsible but she works for me, and that is her program that she is managing with other people, with her staff.

Mr. HARPER. And there are other staff then, multiple people would help her to run that program?

Mr. COHEN. That is true.

Mr. HARPER. And would you be able to provide us a complete list of the staffers who do perform any service connected to the risk corridor program?

Mr. COHEN. Yes.

Mr. HARPER. Thank you. Under this program, if insurers are hit with costs greater than 103 percent of their premiums, the government will give them money. Am I correct?

Mr. COHEN. That is right.

Mr. HARPER. How will——

Mr. COHEN. And there are certain—it is a little more complicated than that but yes.

Mr. HARPER. And I have got a couple of follow-up questions that may allow you to answer that. How will the determination be made of what these costs are? I mean, is there a form or——

Mr. COHEN. The insurance companies will have to present data to us on their health care expenditures, and then it won't be until 2015 that we actually make any payments under the program.

Mr. HARPER. So can you tell us exactly how the insurers will report this? I know it has to be—they are going to report it, but how are they going to report it?

Mr. COHEN. There will be forms or templates or whatever that they will have to provide to us, the accounting information that will tell us what their health care spending has been.

Mr. HARPER. And I have got follow-up too on some enrollment questions if I can shift over to that.

Mr. COHEN. Sure.

Mr. HARPER. The most important number, as has been reported by many news outlets, is whether individuals have paid. Does the Administration collect this information? I am just asking, do you collect this information?

Mr. COHEN. Right now we are not but we will be.

Mr. HARPER. When?

Mr. COHEN. As soon as that functionality is built. I think I answered some questions about that earlier, that not all of that functionality is built yet.

Mr. HARPER. Will that mean then that we have to go back all those that are enrolled, find out whether or not they paid so they

will have to go back to those that are already in? We are not collecting it as it occurs?

Mr. COHEN. We ultimately will reconcile to make sure that advanced premium tax credits, for example, are not paid with respect to anyone who didn't pay their premium because that is a requirement, that you pay your premium in order to get the tax credit.

Mr. HARPER. What department would have this data?

Mr. COHEN. It is going to come to my office.

Mr. HARPER. Who would be the individual that would be in charge of that operation?

Mr. COHEN. That is also Sharon Arnold.

Mr. HARPER. So we don't know at this point how many people have actually paid for coverage?

Mr. COHEN. That is right.

Mr. HARPER. So are you telling me that you don't have any data, you haven't received any information as to who has paid or you just haven't compiled it yet?

Mr. COHEN. We have gotten enrollment data from the issuers with respect to the APTC payments that we are going to be making next week but it is not on an individual basis. So they have told us who—the number of people who are enrolled and who have paid but we don't have it on an individual basis.

Mr. HARPER. Am I——

Mr. COHEN. Ultimately we will.

Mr. HARPER. And I didn't mean to cut you off, Mr. Cohen. Are you telling me you are going to be paying insurers without knowing whether or not the insureds have been paid?

Mr. COHEN. No, we are going to be relying on data from them as to who has paid but we don't yet have an automated system——

Mr. HARPER. So if you are relying on that——

Mr. COHEN. And we will reconcile that as soon as—make sure that those numbers are reconciled and are correct once we do have the capability of receiving the additional data.

Mr. HARPER. All right. Well, do you know the total amount of paid from each insurer at this point since you are relying on that data?

Mr. COHEN. Yes, we have information on what we are going to be paying to each insurer in this first group of payments that is going out next week. We do have that.

Mr. HARPER. Can we go ahead and get the data that you do have, whether it is compiled or not?

Mr. COHEN. I am sure you can.

Mr. HARPER. All right. I believe my time is almost expired. I will yield back.

Mr. MURPHY. The gentleman yields back. I now recognize the gentleman from Colorado, Mr. Gardner, for 5 minutes.

Mr. GARDNER. Thank you, Mr. Chairman, and thank you, Mr. Cohen, for your time today.

I too received my insurance cancellation. Have you ever met anybody who had their insurance canceled?

Mr. COHEN. You may be the first.

Mr. GARDNER. That is pretty shocking, because 335,000 people in Colorado alone had their insurance canceled. The letter that I got that told me that it would be cancelled included this option: your

option includes purchasing another individual health plan from us, purchasing a health plan from another carrier or purchasing a new plan through Connect for Health Colorado. Was the President's promise that I could keep my health care plan upheld? The President's promise to me, was that upheld?

Mr. COHEN. Well, we have talked about this a lot. The law provided that insurance companies could keep the existing plans as long as they didn't make significant changes to benefits and cost sharing. Insurance companies made different choices. There are still a lot of grandfathered plans out there, and those maintain, but then there were other plans that did not continue into 2014. In some cases, those plans were canceled.

Mr. GARDNER. So was the President's promise upheld to me? I mean, I don't remember the President saying there are qualifications if you like your health care plan. There is no asterisk.

Mr. COHEN. The law made it possible for everyone who is in an existing plan as of the time it was passed for that plan to be maintained but it didn't require insurance companies to continue offering them.

Mr. GARDNER. So the President——

Mr. COHEN. What we did—so what we did in November was, we offered another opportunity to say to insurance companies, you can keep those plans in place even if they didn't meet the requirements of the grandfathering provisions.

Mr. GARDNER. So these changes to allow that, these are big changes that you have to—or would a $5 change require them to discontinue the plan?

Mr. COHEN. It was a percentage change that was in the regulation as to how much—and it wasn't a change in premium, it was a change in benefits or cost sharing.

Mr. GARDNER. So a copay of $5, that would require you to lose your insurance then?

Mr. COHEN. I think that was one of the requirements.

Mr. GARDNER. And so is that a significant change to an insurance policy, in your opinion?

Mr. COHEN. Well, if a copay was $20 and it goes up $5, that is pretty significant, yes.

Mr. GARDNER. So the President's promise, he said—so really, in your mind, he shouldn't have even had to apologize because he didn't do anything wrong.

Mr. COHEN. I think the President said that he recognized that what he had said did not prove to be true for many Americans, and as a result of that, we offered another transitional policy to make it be more possible for more Americans to get plans.

Mr. GARDNER. And do you have legal opinions that give the President the authority to make these extensions and changes? Could you provide me with a legal memorandum that——

Mr. COHEN. I would have to—I honestly don't recall whether we had a legal opinion on that issue.

Mr. GARDNER. You testified in September, as we talked about, before the committee talking about everything going fine, and it would be fine. When did you first know that it wasn't going fine? Was it September 27th, 28th, October 1st?

Mr. COHEN. October 1st.

Mr. GARDNER. So you had no indication prior to October 1st that things weren't going well?

Mr. COHEN. I had no indication prior to October 1st that we are going to have the major, major problems with the Web site that we ended up having.

Mr. GARDNER. When did you first know that people would have their insurance canceled?

Mr. COHEN. I think we have always known that not all of the grandfathered plans were going to continue. I don't think we had necessarily a sense of how many would and how many wouldn't.

Mr. GARDNER. When do you expect small business plans to start canceling insurance?

Mr. COHEN. That will likely happen throughout the course of the year. Small business plans don't tend to all come up for renewal in January. Many of them were renewed early in 2013 so that they will continue——

Mr. GARDNER. And how many do you anticipate being canceled?

Mr. COHEN. I don't have a number on that. We can look to see if we can come up with a number.

Mr. GARDNER. If you could provide an estimation of how many additional insured you think will be canceled, that will be great.

And so do we have an idea of how many signed up through the federal exchange so far? I know some of this we have talked about before but how many people have signed up through the federal exchange?

Mr. COHEN. Well, we reported that through December 28th, it was 2.2 million in the federal and the state, and of those, it was something over 1.1 million that were in the federal.

Mr. GARDNER. OK. So about 1.1 million in federal, 1.1 million in States?

Mr. COHEN. Roughly, yes.

Mr. GARDNER. OK. How many of those who signed up in exchanges were not previously insured?

Mr. COHEN. I don't have that number.

Mr. GARDNER. How many were previously insured but had their insurance canceled and now signed up in the federal exchange?

Mr. COHEN. I don't have that number either.

Mr. GARDNER. How many saw their insurance rates go up?

Mr. COHEN. I don't have that number.

Mr. GARDNER. But you said that you know of a significant number of people who saw their rates go down?

Mr. COHEN. As we have been hearing——

Mr. GARDNER. So you don't know for sure if their rates went down. You are hearing anecdotal evidence.

Mr. COHEN. We are hearing anecdotally, and I think——

Mr. GARDNER. So you don't have any concrete numbers on whether rates went up or down?

Mr. COHEN. I think that we know that for people who are eligible for a subsidy that, for those people, it is almost certain that their costs would have gone down.

Mr. GARDNER. So you have some numbers but you don't know how many went up. OK.

So of the supposed 45 million without insurance, how many people now have insurance?

Mr. COHEN. I don't think we have that number yet but certainly we are going to try to come up with as good data as we can as we go forward, you know, to the end of open enrollment.

Mr. GARDNER. How do we know the law is working?

Mr. COHEN. Well, we know the law is working for many people and we know that——

Mr. GARDNER. But you don't know how many of the uninsured are now insured. You don't know how many people saw their rates go up versus rates go down. Insurance companies aren't being paid yet.

Let us talk about the risk corridor provisions. What is the probability of the risk corridor provision being utilized or activated?

Mr. COHEN. Utilized?

Mr. COHEN. What is the probability of the risk corridor language being utilized?

Mr. COHEN. Oh, I mean, I think there will be a risk corridor program.

Mr. GARDNER. No, but I mean, when is the provision of that language being activated and payments being made from the government to insurance companies? What is the probability of that?

Mr. COHEN. Oh, that will happen.

Mr. GARDNER. So you are saying that the government will be paying private insurance companies——

Mr. COHEN. Oh, how likely is it that there will be claims on the program?

Mr. GARDNER. Yes.

Mr. COHEN. I think we anticipate that there will be claims on the program but there also may be some whose costs are lower than what they anticipated and there will be payments into the program, and I think the estimate was that it was budget neutral.

Mr. MURPHY. The gentleman's time is expired. Dr. Burgess, do you have a follow-up question on something? I am just going to give you 30 seconds.

Mr. BURGESS. I know we will have to do this for the record, Mr. Cohen. We are interested in any legal memoranda that you have been advised of or briefed on that define the authority under the Affordable Care Act to delay implementation or the authority to exercise enforcement discretion over enforcement provisions. We all know this law that was signed in March of 2010 bears no resemblance to what is actually going on today because of the variety of enforcement discretions and delays that have been implemented by the Administration. We would like to know under what legal authority you are operating or what you have seen that gives you the legal authority to do so. Thank you, Mr. Chairman.

Mr. MURPHY. And you will provide that for the record, Mr. Cohen?

Mr. COHEN. We will certainly take that request back and work with you.

Mr. MURPHY. I would also like you to follow up with the other questions that members on both sides of the aisle asked as follow-up questions. I would really like to know Mr. Gardner's answers to his questions he asked about, just how many people of the 45 million that were originally supposed to be helped are signed up and if it is more or less expensive for them.

And I ask unanimous consent that the written opening statements of other members who wish will be introduced into the record.

And in conclusion, I would like to thank the witness and the members that participated in today's hearing and remind members they have 10 business days to submit questions for the record, and I ask, Mr. Cohen, if you would please agree to respond promptly to the questions, and with that, this committee hearing is adjourned.

[Whereupon, at 11:42 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

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CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

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MEMORANDUM

January 16, 2014

To: Energy and Commerce Committee Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Comparison of Affordable Care Act and Medicare Part D Enrollment Numbers

This memorandum compares the pace of enrollment in the new federal and state exchanges under the Affordable Care Act (ACA) with the pace of enrollment in Medicare Part D. It finds that Americans are signing up for health insurance under the ACA at a considerably faster rate than seniors signed up for Medicare Part D.

The Congressional Budget Office (CBO) estimated that 23 million seniors would sign up for prescription drug coverage under Medicare Part D during the first enrollment period. By December 31, 2005, only 5.4 million seniors chose to enroll in Part D, just 23% of the estimate. By June 2006, when the open enrollment period ended, Part D enrollment was just 70% of the enrollment estimated by CBO. Republican leaders did not view this as a negative because lower enrollment meant lower costs to the taxpayer. In January 2007, when he was House Minority Leader, Rep. John Boehner argued that Medicare Part D was a success because "the cost of Medicare Part D … is 30 percent less than it was estimated to cost."

Enrollment in the Affordable Care Act is running ahead of enrollment in Medicare Part D. As of December 28, 2013, 2.2 million Americans have enrolled in coverage through the new federal and state exchanges. This is 31% of CBO's estimate of 7 million enrollees during the first year of coverage. This is an impressive enrollment rate, especially given the many problems experienced by the Healthcare.gov website in October and November. Nonetheless, Republican leaders have been sharply critical of these strong enrollment results, claiming that "the administration's enrollment numbers don't paint a pretty picture."

I. MEDICARE PART D ENROLLMENT FIGURES

As the Bush Administration prepared for the opening of enrollment in Medicare Part D, the Congressional Budget Office predicted 29 million seniors would enroll for coverage in

2006.[1] CBO estimated that 6.2 million of those beneficiaries would be dual eligible enrollees who were automatically enrolled in a drug plan and that the remaining 23 million would be individuals who chose to sign up for a Medicare Part D plan or Medicare Advantage drug plan.

But actual enrollment prior to January 1, 2006 - the first day of coverage - was well below these estimates: only 5.4 million people had chosen to enroll in Part D plans under traditional Medicare or Medicare Advantage.[2] These 5.4 million represented only 23% of the 23 million beneficiaries that CBO estimated would sign up by the end of the open enrollment period.[3] Despite these low estimates, Republicans were optimistic, with Department of Health and Human Services (HHS) Secretary Mike Leavitt telling reporters that the Administration was "well on track to meet our goal of enrolling 28 million to 30 million the first year."[4]

Medicare Part D enrollment continued to increase until the end of the Part D open enrollment period. Between January 1, 2006, and June 2006, the number of seniors choosing to enroll in Part D plans almost tripled, increasing from 5.4 million to 15.9 million.[5] Still, the 15.9 million seniors voluntarily enrolled in Part D by June 2006 represented only 70% of the total first-year enrollment expected by CBO and the Administration.[6]

Despite the fact that Medicare Part D enrollment did not meet projections, the Bush Administration described the final enrollment figures as a "historic success."[7] One point that Republicans made frequently was to emphasize one of the consequences of the lower than expected enrollment: lower than expected costs. In January 2007, Rep. John Boehner – who was then the Minority Leader and is now Speaker of the House – asserted that "the cost of Medicare Part D … is 30% less than it was estimated to cost."[8] A Centers for Medicare and Medicaid Services (CMS) press release touted that "estimates for the Medicare Part D prescription drug benefit . . . show that net Medicare costs are 30% less -- $189 billion lower – than were originally predicted."[9]

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[1] Congressional Budget Office, *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug* Benefit (July 2004) (online at www.cbo.gov/sites/default/files/cbofiles/ftpdocs/56xx/doc5668/07-21-medicare.pdf).

[2] Kaiser Family Foundation, *Prescription Drug Coverage Among Medicare Beneficiaries* (June 2006) (online at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7453.pdf).

[3] *Id.*

[4] *HHS Works to Fix Drug Plan Woes,* The Washington Post (Jan. 18, 2006).

[5] Kaiser Family Foundation, *Prescription Drug Coverage Among Medicare Beneficiaries* (June 2006) (online at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7453.pdf).

[6] *Id.*

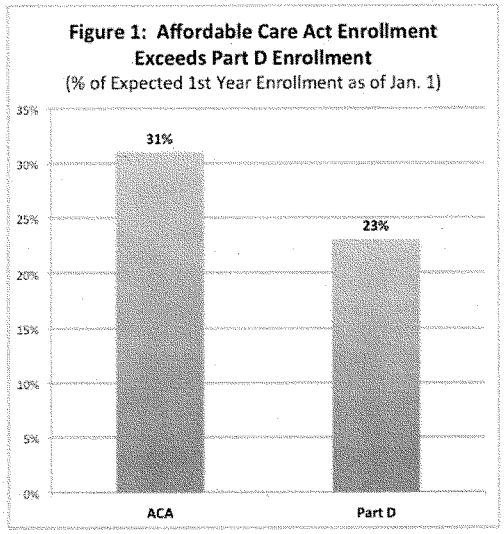
[7] *New Medicare Drug Plan is Called a Success,* Washington Post (May 17, 2006).

[8] Rep. John Boehner, Press Conference (Jan. 11, 2007).

[9] *Projected Medicare Part D Costs Drop by 30 Percent,* Center for Medicare and Medicaid Services (Jan. 8, 2007).

II. AFFORDABLE CARE ACT ENROLLMENT FIGURES

The early pace of enrollment in the Affordable Care Act exchanges is more rapid than Medicare Part D enrollment. As of December 28, 2013, 2.2 million individuals have enrolled in health coverage through the exchanges.[10] CBO estimated that 7 million individuals would enroll by the end of the enrollment period.[11] These early results show that 31% of CBO's enrollment estimate was met by January 1, well above the 23% mark hit during the 2006 Part D rollout. (See Figure 1)



Despite these numbers, the reaction of Republican leaders has been negative. In November 2013, when the first ACA enrollment numbers were released, Speaker John Boehner called them "a symbol of the failure of the president's health care law."[12] In January 2014, a spokesman for Speaker Boehner said, "There's no way to spin it: youth enrollment has been a

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[10] U.S. Department of Health and Human Services, *Health Insurance Marketplace: January Enrollment Report* (Jan. 13, 2014) (online at http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib_2014jan_enrollment.pdf).

[11] Congressional Budget Office, *CBO's February 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage* (May 2013) (online at http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf).

[12] Statement of Speaker John Boehner (Nov. 13, 2013).

bust so far."[13] Sen. Thad Cochran stated in January that "the administration's enrollment numbers don't paint a pretty picture" and that "there is ample reason to be skeptical that those numbers will improve substantially."[14]

III. CONCLUSION

The pace of enrollment under the ACA is faster than the pace of enrollment under Medicare Part D. But this good news is not reflected in the comments of Republican leaders in Congress. In the case of Medicare Part D, Republican leaders portrayed the failure of Medicare Part D to meet CBO estimates as a positive because it meant the costs of the program fell below CBO estimates. In the case of the ACA, they are taking the exact opposite approach and criticizing the Administration for not achieving even higher enrollment figures.

[13] Statement of Brendan Buck, Press Secretary, Speaker John Boehner (Jan. 13, 2014).

[14] *GOP Suspicious of Obamacare Enrollment Figures*, CBS News (Jan. 11, 2014) (online at http://www.cbsnews.com/news/gop-suspicious-of-obamacare-enrollment-figures/).

Congress of the United States
Washington, DC 20515

MEMORANDUM

January 9, 2014

To: Democratic Members and Staff

Fr: Ranking Members Henry A. Waxman and Elijah E. Cummings

Re: Healthcare.gov Security Issues

On Friday, the House will vote on H.R. 3811, the Health Exchange Security and Transparency Act. This legislation would require that the Department of Health and Human Services (HHS) notify individuals within two days of a known security breach of the Healthcare.gov website. This memo summarizes three key points from our Committees' investigations: (1) there have been no successful security attacks to date on Healthcare.gov; (2) Healthcare.gov does not collect or store detailed personal health information; and (3) HHS already has in place protocols for informing affected citizens as rapidly as possible in the event of a security breach.

I. NO SUCCESSFUL SECURITY ATTACKS ON HEALTHCARE.GOV

On December 11, 2013, members and staff of the Committee on Energy and Commerce received a classified briefing from Dr. Kevin Charest, HHS Chief Information Security Officer, and Ned Holland, HHS Assistant Secretary for Administration. Portions of this briefing were classified to protect information relevant to national security. HHS provided an updated briefing two days ago, on January 7, 2014.

According to Dr. Charest, no person or group has hacked into Healthcare.gov, and no person or group has maliciously accessed any personally identifiable information from users.

HHS officials also have confirmed on multiple occasions during transcribed interviews with the Committee on Oversight and Government Reform that there have been no successful security breaches to date. For example, on December 17, 2013, Teresa Fryer, the Chief Information Security Officer at CMS, stated: "There has been no successful — no successful

breaches, security incidents."[1] Ms. Fryer explained that "[a]ll systems are susceptible to attacks," but there have been "no successful attempts" to date.[2]

On December 19, 2013, Oversight Committee staff conducted a transcribed interview of Darrin Lyles, Information System Security Officer at CMS, who confirmed Ms. Fryer's report in the following exchange:

> Q: Miss Fryer told us, I believe yesterday, that there had been no successful security breaches or incidents.
>
> A: I would agree with that.[3]

In fact, after briefing the Energy and Commerce Committee on Tuesday, Dr. Charest, the HHS Chief Information Security Officer, was interviewed yesterday for more than five hours by Oversight Committee staff, and he agreed that "no malicious actors have successfully attacked the Healthcare.gov system."[4]

Government information technology systems are under constant attack by domestic hackers, foreign entities, and others wishing to harm U.S. national interests, and there have been several reported breaches of defense and other agency systems over the past decade. In the case of the Healthcare.gov website, however, evidence obtained by the Committees shows that there have been no successful security attacks to date. HHS officials are complying with the Federal Information Security Management Act and its implementing regulations, and they are conducting 24-7 system monitoring and ongoing assessments to ensure and strengthen system security.

II. DETAILED PERSONAL HEALTH INFORMATION IS NOT COLLECTED OR STORED ON HEALTHCARE.GOV

While Republican leaders have claimed that the detailed personal medical information of users is at risk on the Healthcare.gov website, this is not the case. This is because the website does not collect detailed information about the health status of consumers. Instead, applicants submit a limited amount of information, such as their names, addresses, income levels, and the number of family members to be covered.

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[1] House Committee on Oversight and Government Reform, Transcribed Interview of Teresa Fryer, Chief Information Security Officer, Centers for Medicare and Medicaid Services (Dec. 17, 2013).

[2] *Id.*

[3] House Committee on Oversight and Government Reform, Transcribed Interview of Darrin Lyles, Information Systems Security Officer, Centers for Medicare and Medicaid Services (Dec. 19, 2013).

[4] House Committee on Oversight and Government Reform, Transcribed Interview of Dr. Kevin Charest, Chief Information Security Officer, Department of Health and Human Services (Jan. 8, 2014).

Before the Affordable Care Act went into effect, applying for insurance coverage on the individual market was a complicated process that required the disclosure of extensive health information. Insurance companies were allowed to deny coverage to people with preexisting conditions and, in the process, routinely required applicants to fill out long applications that demanded detailed information on dozens of health conditions, from obesity to mental health disorders to high blood pressure, and even a history of domestic abuse.

Under the Affordable Care Act, insurers are now prohibited from discriminating against people with preexisting conditions, so applicants are not required to submit this type of detailed information on the Healthcare.gov website when they apply for coverage.

III. HHS PROCEDURES FOR INFORMING THE PUBLIC IN THE EVENT OF A SECURITY BREACH

Like all federal agencies, HHS already must notify consumers — consistent with the Federal Information Security Management Act, the Privacy Act, and requirements set forth by the Office of Management and Budget (OMB) — of breaches to their personally identifiable information (PII).

OMB Memorandum M-07-16 establishes a minimum framework for notifying individuals of breaches and notes that "agencies may implement more stringent policies and procedures."[5] This protocol requires agencies to provide consumers with "notification without unreasonable delay following the discovery of a breach."[6] Agencies must report all breaches involving PII to US-CERT at the Department of Homeland Security (DHS), and individuals mus receive a comprehensive written notification package, including a description of what happened, the dates of the breach and the discovery, how the information was encrypted or protected, next steps for individuals to protect themselves, what the agency is doing to investigate the breach, and who to contact at the agency for more information.[7]

To implement these guidelines, HHS issued its "Personally Identifiable Information (PII) Breach Response Team (BRT) Policy," which states that the agency "shall ensure that notifications are made to the affected individuals."[8] The policy gives HHS up to 60 days to investigate security incidents, such as a missing laptop containing PII. HHS officials say that their practice is to act much more quickly. If HHS confirms that an individual's PII has been breached, HHS notifies the person as rapidly as possible.

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[5] Office of Management and Budget, *Safeguarding Against and Responding to the Breach of Personally Identifiable Information M-07-16* (May 22, 2007) (online at www.whitehouse.gov/sites/default/files/omb/memoranda/fy2007/m07-16.pdf).

[6] *Id.*

[7] *Id.*

[8] Department of Health and Human Services, *Personally Identifiable Information (PII) Breach Response Team (BRT) Policy HHS-OCIO-2008-0001.003* (Nov. 17, 2008) (online at www.hhs.gov/ocio/policy/20080001.003.html).

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ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

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February 3, 2014

Mr. Gary Cohen
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Mr. Cohen:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Thursday, January 16, 2014, to testify at the hearing entitled "2014: Seeking PPACA Answers."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Monday, February 17, 2014. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

Gary Cohen's Hearing
"2014: Seeking PPACA Answers"
Before
Energy & Commerce Committee
Oversight & Investigations Subcommittee

January 16, 2014

Attachment 1—Additional Questions for the Record

The Honorable Cory Gardner

1. **According to a 2012 Report issued by HHS, "[Congressional Budget Office] did not score the impact of risk corridors and assumed collections would equal payments to plans and would therefore be budget neutral." [Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Exchange Standards for Employers (CMS-9989-FWP) and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (CMS-9975-F), Regulatory Impact Analysis, March 2012]**

    a. **Was the intention of the risk corridor program to be budget neutral?**
    b. **What is the expected cost now?**

Answer to 1a & b: Section 1342 of the Affordable Care Act directs HHS to establish a temporary risk corridors program during the years 2014 through 2016.The overall goal of the temporary risk corridor program is to help stabilize health insurance premiums during the transitional period of the first few years of the coverage expansion.

Risk corridors will help protect against potentially inaccurate rate-setting by sharing risk on allowable costs between CMS and qualified health plans. Many people enrolling in coverage through the Marketplace are people who were previously uninsured and health plans have little or no data to predict the future services needs of these enrollees and estimate premiums. These unknowns may result in some plans being underpriced, and others overpriced. This temporary program stabilizes premiums while issuers gain more experience in competing in the Marketplace, and are able to price their plans accordingly.

The estimate for the Risk Corridors program in the President's FY 2014 Budget shows net zero costs over the course of the program, reflecting that the program has been estimated to pay out the same amount of money as it collects from health insurance issuers.

2. **On November 14, 2013, President Obama announced a new transitional relief policy for 2014 under which individuals and small businesses whose insurance coverage had been or would be cancelled under the Affordable Care Act would be able to keep their coverage for an additional year. This announcement was made after insurance companies set their rates for 2014. Did the administration assess the potential impact of**

this new policy on the risk corridor program? If so, what were your findings? If not, why not?

3. **In a December 19, 2013 letter from HHS Secretary Kathleen Sebelius to Sen. Mark Warner, the Administration changed the rules again by allowing people whose policies had been cancelled because of the Affordable Care Act's new requirements to purchase catastrophic plans, which were previously restricted to people under 30 or those who qualified for a hardship exemption. Did the administration assess the potential impact of this new policy on the risk corridor program? If so, what were your findings? If not, why not?**

4. **A November 14, 2013 letter from CMS to state insurance commissioners states: "Though this transitional policy was not anticipated by health insurance issuers when setting rates for 2014, the risk corridor program should help ameliorate unanticipated changes in premium revenue. We intend to explore ways to modify the risk corridor program final rules to provide additional assistance."**

    a. **What modifications to the risk corridor program are expected?**

    b. **How much will these modifications cost?**

    c. **Based upon the new situation, do you expect to seek a score from the CBO?**

    d. **If there is a systemic failure of the health insurance industry, will the risk corridor program be used to bail out the industry?**

Answer to #s2-4: As a part of the proposed 2015 HHS Notice of Benefit and Payment Parameters,[1] we announced that we are considering a number of approaches to potentially mitigate the potential effects, if any, of this transitional policy, including a proposal for an adjustment to how administrative costs and profits are calculated under the risk corridors program.

<u>The Honorable Bruce Braley</u>

1. **Section 2706(a) of the Affordable Care Act prohibits health insurance plans from discriminating against entire classes of licensed and certified health care professionals on the basis of the provider's licensure or certification. This provision helps to ensure that patients have access to the care they need when and where they need it.**

    Unfortunately, CCIIO released a flawed FAQ on the provision ahead of its 1/1/14 implementation date and some states are now being forced to improperly implement Section 2706 based on CCIIO's flawed FAQ. The underlying problem is that an FAQ is now dictating policy that is different than both the intent of the provision and the language that Congress passed and the President signed into law.

[1] http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28610.pdf

May I receive your assurance that action will be taken by CMS to rectify this situation and that you will direct the Center for Consumer Information and Insurance Oversight to immediately work with the Department of Labor and Department of Treasury to withdraw and rescind this flawed FAQ guidance? May I also receive your assurance that you will, after rescinding the guidance, alert health insurers and states to the fact that CCIIO has withdrawn the flawed FAQ?

Answer: The statutory language of section 2706(a) of the Public Health Service Act is applicable to non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage for plan years (in the individual market, policy years) beginning on or after January 1, 2014.

Until any further guidance is issued, group health plans and health insurance issuers offering group or individual coverage are expected to implement the requirements of section 2706(a) using a good faith, reasonable interpretation of the law.

The Departments will work together with employers, plans, issuers, states, providers, and other stakeholders to help them come into compliance with the provider nondiscrimination provision and will work with families and individuals to help them understand the law and benefit from it as intended.

Attachment 2—Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Tim Murphy

1. **Is there a set date for completion of the back end of the Federally Facilitated Marketplace (FFM)?**

Answer: We're working closely with issuers through a systematic and meticulous process to ensure consumers are correctly enrolled.

2. **How much money has been budgeted for advertisements during the Olympics? Where is this funding coming from?**

Answer: We are spending $4.4 million during the Olympics, as part of the larger Weber Shandwick contract. Ads will run in the markets with the highest rates of uninsurance.

The Honorable Michael C. Burgess

1. **Please provide us with any additional information you have regarding the build of the back end, as well as the provider payments portion of HealthCare.gov i.e. the percentage of payments that have been processed.**

Answer: We're working closely with issuers through a systematic and meticulous process to ensure consumers are correctly enrolled.

2. **Please provide the Committee with any communications regarding ongoing discussions that are happening between you and OMB with regard to seeking appropriation for the risk corridor language in the law.**

Answer: I have not been in communication with OMB with regard to seeking appropriations language for the risk corridor program.

3. **Please provide any legal memorandum that has been prepared for you or your department regarding the risk corridor adjustment and whether that money will be coming from taxpayer dollars or funds that have already been appropriated for the Affordable Care Act.**

Answer: The Department of Health and Human Services has not prepared legal memoranda on this topic at this time.

4. **Please provide any legal memorandum that you have been advised of or briefed on that defines the authority under the Affordable Care Act to delay implementation or the authority to exercise enforcement discretion over enforcement provisions.**

Answer: The Department of Health & Human Services has not prepared legal memoranda on this topic.

The Honorable Marsha Blackburn

1. **You testified that you are receiving regular and detailed briefings. Can you please quantify those briefings and list what types of briefings you are having?**

Answer: I receive regular and detailed briefings on an ongoing basis regarding a variety of policy and operational issues. These briefings are conducted through a variety of means, including in person, teleconference, and by phone.

The Honorable Gregg Harper

1. **Please provide us with a complete list of the staffers who perform any services connected to the risk corridor program.**

Answer: As Director of CCIIO, I over see the risk corridor program.

2. **Please provide the Committee with information regarding the total amount of money that you paid each insurer in this first group of payments that you mentioned during the hearing.**

Answer: The first payments to issuers are expected to begin next week. Payments to issuers are ultimately disbursed by the Department of the Treasury, after being processed through the CMS financial management system. We expect the first payments to be relatively small since they only cover individuals eligible for tax credits and cost sharing reductions who enrolled prior to December 15th.

The Honorable Pete Olson

1. **Please provide the Committee with a copy of the instructions you issued to Navigators telling them that they should not engage in door-to-door solicitation.**

Answer: As a part of the CMS Navigator Grantee Guide issued on September 20, 2013, grantees were instructed that "outreach activities should not include door-to-door activities to help consumers fill out applications or enroll in health coverage." The Committee has posted a copy of the guide on its website.[2]

[2] http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/20130920Final-CMS-Navigator-Grantee-Guide.pdf

The Honorable Cory Gardner

1. **Please provide the Committee with any legal opinions or memorandums that gave the President the authority to mandate insurance companies to allow their members to keep current plans through 2014.**

Answer: The Department of Health & Human Services has not prepared legal memoranda on this topic.

2. **How many small business insurance plans do you anticipate being canceled?**

Answer: The small businesses market for health insurance differs from the individual market; small businesses enroll, renew, or drop their insurance plans throughout the calendar year. Many small businesses renewed their plans in late 2013 and will be making decisions this year on the future coverage.

3. **How many people who signed up in the exchanges were not previously insured? How many were previously insured but had their insurance canceled and are now signed up in the federal exchange?**

4. **How many individuals saw their insurance rates go up after signing up in the federal exchange?**

5. **Of the supposed 45 million people without insurance, how many people now have insurance?**

Answer for #s 3-5: Our most recent enrollment report shows that nearly 2.2 million people have enrolled in a private health insurance plan through the Federal and State-based Marketplaces since October 1,[3] and in October and November, 3.9 million individuals learned they are eligible for coverage through Medicaid and CHIP.[4,5] We expect these numbers to continue to grow because (1) open enrollment continues through March; (2) special enrollment periods are available for those with a change in circumstance; and (3) eligible individuals can enroll in Medicaid throughout the year.

The premiums being charged by insurers provide clear evidence that the Marketplace is encouraging plans to compete for consumers, resulting in more affordable rates. The weighted average premium for the second-lowest-cost silver plan, looking across 47 states and DC, is 16 percent below the premium level implied by earlier Congressional Budget Office (CBO) estimates.[6] Outside analysts have reached similar conclusions. A recent Kaiser Family Foundation report found that, "while premiums will vary significantly across the country, they are generally lower than expected," and that fifteen of the eighteen states examined would

[3] http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib_2014jan_enrollment.pdf
[4] These numbers include new eligibility determinations and some Medicaid and CHIP renewals.
[5] http://www.hhs.gov/healthcare/facts/blog/2013/12/nationwide-enrollment-surges.html
[6] http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/ib_marketplace_premiums.cfm#_ftnref18

have premiums below the CBO-projected national average of $320 per month for a 40-year-old in a silver plan.[7]

The Honorable Bill Johnson

1. How many contractors are involved and dedicated to the security of HealthCare.gov?

Answer: The privacy and security of consumers' personal information are a top priority for the Department. When consumers fill out their online Marketplace applications, they can trust that the information they are providing is protected by a comprehensive set of security standards and practices. Security testing happens on an ongoing basis using industry best practices to appropriately safeguard consumers' personal information. The components of the FFM that are operational have been determined to be compliant with the Federal Information Security Management Act, based on standards by the National Institutes of Standards and Technology and on those promulgated through OMB. Additionally, all of CMS's Marketplace systems of records are subject to the Privacy Act of 1974 and the Computer Security Act of 1987.

Security is a consideration throughout the software development process, so a variety of contractors that have contributed to the developed of the Federally-facilitated Marketplace have also contributed to its security. CMS has used other contractors for certain security specific tasks.

2. How much money is being spent to provide security to HealthCare.gov?

Answer: As of October 31, 2013, total IT cost outlays total $319 million. This total includes funds spent on Healthcare.gov. As security controls are integrated into overall IT activity, we are not able to single out funding for security specifically.

3. During the hearing you stated that you are given reports on the security of HealthCare.gov. Please provide the Committee with examples of those reports so we can see what those reports include.

Answer: Independent security testing on the Federally-facilitated Marketplace (FFM) with written audit reports known as Security Control Assessments is a robust and ongoing progress. In addition to regular independent security testing, ongoing security testing is conducted using industry best practices. This ongoing security testing include weekly penetration testing, ongoing monitoring by sensors and other tools to deter and prevent unauthorized access, and scanning by automated tools for vulnerabilities. These continuous and weekly tests are reported to CMS security experts.

CMS treats these reports, in accordance with guidance from the National Institute of Standards and Technology, as sensitive, protected information that is highly confidential because they contain detailed information about the Agency's information systems, and the disclosure of this information could put the systems and personally-identifiable information at risk.

[7] http://kaiserfamilyfoundation.files.wordpress.com/2013/09/early-look-at-premiums-and-participation-in-marketplaces.pdf

The Honorable Billy Long

1. **Please provide the Committee with the data that breaks down the total number enrollees into the number of people who were previously uninsured versus the number of people who may have been insured before the Affordable Care Act implementation and have since switched to new coverage.**

Answer: Our most recent enrollment report shows that nearly 2.2 million people have enrolled in a private health insurance plan through the Federal and State-based Marketplaces since October 1st,[8] and in October and November, 3.9 million individuals learned they are eligible for coverage through Medicaid and CHIP.[9,10] We expect these numbers to continue to grow because: (1) open enrollment continues through March; (2) special enrollment periods are available for those with a change in circumstance; and (3) eligible individuals can enroll in Medicaid throughout the year.

The Honorable Renne Ellmers

1. **Of the 3.9 million who have enrolled in Medicaid, how many of them could have previously signed up for Medicaid but did not do so before the Affordable Care Act was implemented?**

Answer: HHS has released data on Medicaid determinations and assessments over the last few months. These data are from various enrollment channels, including Federal and state Marketplaces, as well as state Medicaid and CHIP agencies. We will gain additional understanding on newly eligible Medicaid and CHIP enrollments as states report additional data in the future.

Later this year, States will begin to report to CMS quarterly data on new enrollments under the Affordable Care Act to receive their 100 percent Federal funding for people newly eligible under Medicaid expansion. We will then learn more information about the number of newly enrolled individuals who would have been previously eligible prior to the Affordable Care Act.

[8] http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib_2014jan_enrollment.pdf
[9] These numbers include new eligibility determinations and some Medicaid and CHIP renewals.
[10] http://www.hhs.gov/healthcare/facts/blog/2013/12/nationwide-enrollment-surges.html